Representing Children in Mental Disability Proceedings

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This article explores the legal and ethical issues arising from the representation of children in mental disability proceedings, focusing on the attorney's special obligation under California state law to "advocate for the protection, safety and physical and emotional well-being" of a child client in dependency court and its implications for the attorney providing representation in mental disability proceedings. The article also discusses the emerging field of therapeutic jurisprudence and the difficulty of determining the child client's "therapeutic" needs, as opposed to legal interests.

The article concludes by discussing special concerns when representing children in mental disability proceedings: addressing the client's and family's attitudes toward mental disability and resisting the temptation to play therapist. ■

This article explores the legal and ethical issues arising from the representation of children in mental disability proceedings. The article begins by identifying the different types of these judicial and administrative proceedings in California and then briefly discusses the child's due process rights under the California Constitution and state laws in each context. However, the primary focus of the article is on the special ethical issues facing the lawyer/advocate who represents the child in mental disability proceedings: What is the role of the lawyer/advocate for the child? How are professional obligations to advance the client's interests and preserve client confidences affected by the fact that the client is a child or may have a mental illness or other mental disability? How should the lawyer/advocate determine the client's competency to instruct him or her? If the lawyer concludes that the child client's competency indeed is impaired, should he or she make decisions in the client's "best interest" as would a guardian ad litem?

In considering these questions, the article draws upon professional responsibility standards for the representation of clients with mental disabilities[1] and clients who are children.[2] Particular use is made of the extensive literature on the role of counsel for children. The article also discusses the attorney's obligation under California state law to "advocate for the protection, safety and physical and emotional well-being" of a child client[3] in dependency court and its implications for the attorney providing representation in mental health proceedings.

The discussion next turns to the emerging field of therapeutic jurisprudence.[4] In what ways can or should the lawyer/advocate act "therapeutically" to promote the child client's mental health? Legal representation of children in mental disability proceedings has been criticized as counter-therapeutic, reinforcing the child's denial of mental disability and increasing conflict with parents and therapists. The article explores the difficulty of determining the child client's "therapeutic" needs, as opposed to legal interests, and considers whether effective legal representation, by empowering child clients, can be therapeutic.

The article concludes by proposing principles for representing children in mental disability proceedings. The advocate's need to address client's and family's attitudes toward mental disability and resist the temptation to play therapist rather than lawyer is discussed. Finally, the article recommends and outlines special training to qualify lawyers/advocates for this important and challenging work.

DEFINITIONS

"Mental disability proceeding" is a broad term referring to any judicial or administrative proceeding in which a key issue is whether an individual (in this article a child) has a "mental disability" or "disorder" as defined under relevant law. That key issue may arise in any of several ways:

- The state asserts that a child has a mental disability and, because he or she is dangerous to self or others "or 'gravely disabled,'" requires treatment in a hospital or other secure setting.
- A child who is already the subject of juvenile court jurisdiction may, upon either the court's or his or her own initiative, be referred for mental health evaluation and treatment.
- A child, acting through a parent or another legal representative, may seek to establish that he or she has a mental disability and is therefore entitled to receive appropriate treatment and services—as part of a special education program, for example. This category includes a parent's application for the child to be a "voluntary" patient at a public or private institution.

Thus, depending upon the context, a finding that a child is mentally disabled may help establish entitlement to a benefit that the child voluntarily seeks or may authorize involuntary detention and treatment against the wishes of the child and even his or her parents.

"Legal representation" or "legal advocacy" may be performed by either a lawyer or a lay advocate, depending upon the situation. Legal representation in court normally requires a lawyer; however, advocacy in administrative hearings and hospital contexts may be performed by either a lawyer or a lay advocate. In California a number of advocacy organizations employ both lawyers and advocates who represent children in administrative hearings.[5] This article uses the term "lawyer/advocate" to refer to both types of representatives. The text also indicates where a child's right to counsel refers solely to representation by a lawyer.

MENTAL DISABILITY PROCEEDINGS FOR CHILDREN IN CALIFORNIA

As a general rule, children do not have the same rights as adults to consent to or refuse mental health treatment. California, like other states, permits parents to place their children in public and private mental hospitals or other secure facilities. The state may also commit children by virtue of a different set of criteria from those required for adults and fewer procedural due process protections. Nevertheless, both the California courts and the Legislature have long recognized that children have liberty and privacy rights that are significantly affected by placement and treatment in a mental health facility, and that children may need both state assistance to obtain mental health care and legal protection against inappropriate hospitalization.[6] Thus, in some instances, California statutory or constitutional law provides children with greater due process rights than have been required by the U.S. Supreme Court interpreting the federal Constitution.[7]

Moreover, the Legislature has tried to balance parents' well-established right and duty to seek needed mental health treatment for a child with the state's interest in protecting the child against the unnecessary loss of liberty and stigmatization resulting from erroneous commitment. California judicial and administrative proceedings affecting mentally disabled children include actions under the state children's civil commitment and mental health treatment act; dependency or juvenile court proceedings where treatment of a mental illness or disorder is proposed, either on a voluntary or an involuntary basis; preadmission hearings before parents may place a child in a *public* mental health facility; and postadmission independent clinical reviews requested by a child placed by parents in a *private* facility. In addition, administrative advocates and attorneys provide representation in administrative and judicial proceedings to establish and enforce a mentally disabled child's right to special education or public benefits.

INVOLUNTARY TREATMENT UNDER THE CHILDREN'S CIVIL COMMITMENT LAW

The Children's Civil Commitment and Mental Health Treatment Act (hereinafter Children's Commitment Act),[8] enacted in 1988, governs the short-term involuntary detention and evaluation of minors under the Lanterman-Petris-Short Act (hereinafter LPS Act).[9] "Civil commitment" properly refers to judicial action, but the term tends to be used more broadly in California to apply to any involuntary hospitalization under the LPS Act.

The LPS Act permits involuntary detention and evaluation for 72 hours of an individual who has a "mental disorder" and, as a result of that mental disorder, is a danger to self or others or is "gravely disabled."[10] The act does not define "mental disorder," perhaps acknowledging that the mental health professions are constantly evolving and updating definitions and diagnostic terminology. In California "courts have typically interpreted 'mental disorder' to include any significant mental disorder identified in the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).*"[11] However, mental disorder or disability alone is not sufficient to authorize involuntary detention under the LPS Act: mental disorder *plus* dangerousness to self or others *or* "grave disability" must be found.

The Children's Commitment Act defines "gravely disabled minor" as one who, "as a result of a mental disorder, is unable to *use* the elements of life which are essential to health, safety, and development, including food, clothing,

and shelter, even though provided to the minor by others. Mental retardation, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder."[12] (A "gravely disabled" adult is one who is unable to *provide* him- or herself with the essential elements of life. Because a child is normally not expected to do this, but rather depends upon adults, typically parents, to provide food, clothing, and shelter, the definition of "gravely disabled minor" in the Children's Commitment Act reflects this difference.)

The LPS Act authorizes a peace officer or a mental health professional designated by the county, upon finding probable cause that a minor meets the above criteria, to initially detain him or her for up to 72 hours. The act provides no administrative or judicial review of this first 72-hour hold. The facility must make every effort to notify the minor's parent or legal guardian as soon as possible after detention[13] and to involve the parent or guardian in the clinical evaluation required.[14] That clinical evaluation consists of a "multidisciplinary professional analysis of the minor's medical, psychological, developmental, education social, financial and legal conditions" as well as "a psychosocial evaluation of the family or living environment or both."[15] Despite this proviso, parental consent is not required for detention and evaluation or for involuntary treatment under the Children's Commitment Act.[16] After the initial 72 hours, the minor may be subjected to further involuntary treatment *only* in accordance with the provisions of the LPS Act. Thus, except where the LPS Act indicates to the contrary, minors are entitled to the same statutory due process rights as adults.

Under the LPS Act, after 72 hours an individual (adult or child) may be "certified" for up to 14 additional days of intensive treatment if he or she is still gravely disabled or dangerous to self or others. Such an individual is entitled to an administrative "certification review"(sometimes also called a "probable cause") hearing, conducted by a court-appointed commissioner or referee or a hearing officer. The individual is entitled to assistance by a lawyer or a patients rights advocate.[17] A second 14-day hold for intensive treatment may be authorized for an individual who has made a suicide threat or attempt and continues to pose an imminent danger of suicide;[18] in a limited number of counties a 30-day hold may be authorized for an individual who is gravely disabled and unwilling or unable to accept treatment as a voluntary patient.[19] Both of these extensions to the initial commitment require administrative hearings. An individual who poses a danger of substantial physical harm to others may be held for 180 days;[20] this type of extension requires a judicial hearing. In addition, the LPS Act gives individuals the right to challenge the legality of any of these additional holds by petitioning for a writ of habeas corpus. A hearing on the writ petition must be held within two days of the request, and the individual is entitled to representation by counsel.[21]

Long-term involuntary confinement of a person with a mental disability in a psychiatric facility may be accomplished in the civil system only through an LPS conservatorship.[22] If a court finds that the individual is gravely disabled beyond a reasonable doubt, it may appoint a conservator. The conservator may be authorized by the court to give or refuse consent to treatment related to the grave disability and to place the conservatee in a facility for such treatment.[23] A judge most frequently decides the conservatorship petition; however, there is a right to a jury trial.[24] The standard of proof used is beyond a reasonable doubt.[25]

A conservatee who wishes to challenge the necessity either for the conservatorship or for confinement in a treatment facility may do so in either of two ways. First, under the conservatorship statute itself, the conservatorship must be renewed on a yearly basis,[26] and the conservatee has the right to oppose renewal at a hearing.[27] Second, the conservatee has a constitutional as well as a statutory[28] right to petition for a writ of habeas corpus.

The LPS Act also governs the involuntary use of antipsychotic or other psychotropic[29] medication.[30] The act provides for hearings to determine committed individuals' competency to give or withhold consent to the use of these drugs. These "capacity hearings," or *Riese* hearings, were established after the California Court of Appeal, in *Riese v. St. Mary's Hospital and Medical Center*,[31] found that individuals committed under the short-term detention provisions of LPS[32] are presumed competent and have a right to refuse medication in nonemergency situations. Whether minors committed under the same sections are entitled to capacity hearings is an unsettled area of law.[33] Neither the *Riese* court nor the Legislature in subsequently enacting the capacity-hearing provisions distinguished minors from adults, but rather referred generally to individuals committed under the short-term detention and evaluation sections[34] of the LPS Act. At present only a minority of counties hold capacity hearings for minors.

Moreover, in addition to any statutory right, children who are in fact competent to give or withhold consent to psychotropic medication may have a right to a review of their capacity under the California Constitution. The California Supreme Court recently confirmed that, under the privacy right of the California Constitution, a child who is in fact competent to give or withhold informed consent to an abortion has the right to do so.[35] Even the dissenting justices acknowledged that a competent child

had such a right; they believed, however, that due process was satisfied by offering the child the opportunity to prove his or her competency to a juvenile court.[36] Like the choice whether or not to have an abortion, the decision to give or refuse consent to antipsychotic medications is time-sensitive, has critical importance to the child's future life, and is inextricably linked to the child's personal values.[37] Therefore, a child who has been involuntarily committed by the state and believes him- or herself capable of making an informed decision about antipsychotic medication may well have a right to prove competency in a *Riese*-type hearing.[38]

One of the stated purposes of the Children's Commitment Act is "to safeguard the rights to due process for minors and their families through judicial review."[39] Consistent with this purpose, under the LPS Act minors, just like adults, have the due process rights to certification review hearings (and in a minority of counties, to capacity hearings), including representation by an advocate, and to judicial hearings if confined for 180 days as "dangerous to others" or for one year as "gravely disabled" under an LPS conservatorship. Children are entitled to representation by court-appointed counsel in all such judicial proceedings, as well as in habeas corpus proceedings.

TRANSFER FROM JUVENILE OR DEPENDENCY COURT PROCEEDINGS

A child may be found a "dependent" of the juvenile court if he or she is abused, neglected, or abandoned, or if his or her parents are unwilling or unable to provide proper custody and care.[40] A child may be found to be a "ward" of the juvenile court as either a "status offender"[41] or a "delinquent."[42] A "status offense" is an act such as truancy, curfew violation, or habitual disobedience of parents that is unlawful only for a child. A "delinquent" is a child who has committed an act that would be a crime if committed by an adult.

Hospitalization of a dependent child or a juvenile court ward for evaluation and treatment of a mental illness or disorder may be proposed, either by the court or by the child.

Court-Ordered Evaluation (Welf. & Inst. Code § 6551)[43]

"If the court is in doubt as to whether the [child] is mentally disordered or mentally retarded," the judge can order the child to be taken to a designated LPS facility and evaluated for 72 hours, consistent with LPS procedures.[44] The California Supreme Court, in *In re Michael E.*,[45] held that county representatives, such as caseworkers or probation officers, do *not* have the authority to hospitalize minors under "voluntary" status as a parent could do. Therefore, any ward or dependent of the court may be involuntarily hospitalized only in accordance with the provisions of the LPS Act.

Once the child has been referred for a 72-hour evaluation, the juvenile court proceeding is continued. The evaluation must be completed within 72 hours and a report made to the juvenile court. If the LPS evaluating mental health professional concludes that the child "is not affected with any mental disorder requiring intensive treatment or mental retardation,"[46] the child must be returned to the court promptly and the juvenile court case can proceed. If the evaluating professional finds that the child, as a result of a mental disorder, *is* in need of intensive treatment, he or she can certify the child for 14 days[47] or accept the child's application, on the advice of counsel, for voluntary treatment.[48] Thereafter the child must be treated like any other person involuntarily confined under the relevant sections of LPS.[49] The juvenile court proceedings are suspended during the child's confinement under LPS.

Child's Voluntary Application for Commitment (Welf. & Inst. Code § 6552)

A child found to be a dependent or a ward of the juvenile court may "with advice of counsel, make a voluntary application for inpatient or outpatient mental health services."[50] The court may authorize the child's application if it is satisfied that the "minor suffers from a mental disorder which may reasonably be expected to be cured or ameliorated by a course of treatment offered by the hospital, facility or program in which the minor wishes to be placed; and that there is no other available hospital program or facility which might better serve the minor's medical needs and best interests."[51] Once the child is accepted for treatment by a hospital, facility, or program, the juvenile court proceedings are suspended. Because the child is a *voluntary* patient, he or she can demand to leave the facility or program prior to discharge; if so, the child must be returned to the juvenile court for further disposition of the case.

It is well established that, in any dependency proceeding where the child would benefit from the appointment of counsel, the court must appoint counsel.[52] A child alleged to be a status offender or delinquent is entitled to representation by counsel, either furnished by a parent or guardian or appointed by the court.[53] If the parent or guardian does not furnish counsel and could afford to do so, the court can appoint counsel at his or her expense.[54] The lawyer representing a child in dependency or juvenile court proceedings must advise the child client concerning the option of becoming a voluntary patient: the statute explicitly states that the child's voluntary application may be made only "with advice of counsel."

A child who becomes a voluntary patient based upon his or her own application for treatment is treated like any other voluntary patient under the provisions of the LPS Act. Somewhat confusingly, however, children may also become voluntary patients upon the application of their parents. Children whose *parents* have volunteered them[55] do not have the rights of true voluntary patients to refuse treatment and to leave a program or facility prior to discharge or against the advice of the treating mental health professionals. However, while a child whose parents have applied for voluntary status can be confined and treated in a mental health facility against his or her will, California law does provide some due process procedures for older children facing such confinement.

PREADMISSION HEARINGS BEFORE HOSPITALIZATION IN A PUBLIC MENTAL HOSPITAL UNDER *IN RE ROGER S.*, 19 CAL. 3D 921 (1977)

In *In re Roger S.*, the California Supreme Court held that a child age 14 or older is entitled to a preadmission hearing when a parent seeks to place him or her in a *public* mental health facility.[56] In such a case, the hearing officer must determine, based upon a preponderance of the evidence, whether the child is "mentally ill or disordered and whether, if the [child is] not gravely disabled or dangerous to himself or others as a result of mental illness or disorder, the admission sought is likely to benefit him."[57]

This language permits a mentally disordered child to be hospitalized even if not gravely disabled or dangerous to self or others—in other words, even if he or she does not meet the criteria for involuntary detention and treatment of an adult *or* a child under the LPS Act. As long as the child has a mental disorder and is "likely to benefit" from hospitalization, his or her voluntary admission by a parent is lawful under *Roger S.*

However, because hospitalization and treatment deprive a child of liberty and subject him or her to stigma as mentally ill, the Court found that under both the California and U.S. Constitutions due process protections must be provided. The child is entitled to a hearing by a neutral decision-maker, an opportunity to appear in person and present evidence at the hearing, an opportunity to cross-examine adverse witnesses, and to assistance of counsel.[58]

Roger S., the plaintiff, was 14 years old; reasoning by analogy from juvenile court proceedings in which children of that age were able to waive constitutional rights, the Court concluded that a child age 14 or older has the ability to decide whether to assert or waive such due process rights.[59] Therefore a child may waive his or her *Roger S.* rights and agree to placement in the hospital without a hearing. Such a waiver, to be valid, must be knowing and voluntary and must be based upon consultation with an attorney. The effect of the waiver is that the child is a voluntary patient but, unlike an adult with such status, cannot leave the facility or refuse treatment.

In re Roger S., grounded in the California as well as the U.S. Constitution, provides a minor age 14 and older with greater procedural due process than the U.S. Supreme Court found sufficient in *Parham v. J.R.*[60] In *Parham* the Court upheld as constitutional a Georgia statute authorizing commitment of children to state mental institutions upon the application of a parent or (in the case of state wards) the juvenile court or custodial agency. In *Roger S.* the California Supreme Court found that a similar California statute denied due process to 14-year-old Roger S., who was committed to a state mental hospital on the application of his parent. Both courts found that commitment to a *public* mental hospital, even through the application of a parent, was state action, causing a deprivation of the child's liberty interest and triggering a right to due process protections.[61]

However, the U.S. and California Supreme Courts reached very different conclusions about what process was due. The Court in *Parham* found that due process was satisfied by a review of the appropriateness of the minor's admission by a neutral fact-finder, who could be an employee of the state hospital. A traditional "intake examination" by an employee who had the power to grant or deny admission would suffice.[62] A periodic review of the continuing need for hospitalization was also required, at least for a ward of the state who had been referred by a court or public custodial agency.[63] The U.S Supreme Court reasoned that the risk of erroneous hospitalization was low, since history teaches that the majority of parents act in their children's best interest. If a parent acting in bad faith tried to place an "emotionally normal, healthy" child in a state hospital, the mental health professionals would realize this and either refuse to admit the child or discharge him or her once their evaluation was complete.[64] As to those children who were appropriately hospitalized, the parents' natural affection would also prompt them to seek the child's speedy discharge and return home, thus reducing the risk of unnecessarily long periods of confinement; the wards of the state had no such natural advocate, hence the need for a periodic review.[65]

Although the *Parham* Court acknowledged the loss of liberty and stigma involved in mental hospital confinement,[66] Chief Justice Burger, writing for the majority, opined that what is truly stigmatizing is the behavior of a mentally ill minor whose condition goes untreated.[67] Because parents have the right and indeed the high duty to seek treatment for their mentally ill children, the Chief Jus-

tice was reluctant to require more "time-consuming procedural minuets" before state hospitalization could occur.[68]

The California Supreme Court, faced with the identical issue, reached a different conclusion. While it shared the assumptions that most parents sought hospitalization for their children in good faith,[69] it considered erroneous admission a more serious problem, for two reasons. First, it discussed at length the stigma associated with mental illness[70] and especially with hospitalization in a public facility whose patient population includes severely mentally ill and dangerous individuals.[71] Second, it defined "erroneous admission" much more broadly to include hospitalization of a mentally ill child who could appropriately be treated in a less restrictive setting.[72] The hearing officer, in determining whether the child can "benefit from" hospitalization, is supposed to consider less restrictive alternatives, especially those resources that would permit the child to remain in his or her home community.

Significantly, the *Roger S.* majority, in establishing a right to counsel, refers to the importance of exploring alternatives to hospitalization that may meet the minor's treatment needs:

> Inasmuch as a minor may be presumed to lack the ability to marshal the facts and evidence, to effectively speak for himself and to call and examine witnesses, or *to discover and propose alternative treatment programs,* due process also requires that counsel be provided for the minor.[73] (Italics added.)

The lawyer/advocate may counsel a child prior to waiver or represent him or her in the *Roger S.* hearing. There is considerable variation among counties about what form *Roger S.* hearings take, where they take place, and who is appointed to counsel or represent the child.[74]

INDEPENDENT CLINICAL REVIEW REQUESTED BY THE CHILD (WELF. & INST. CODE § 6002.15)

The facts and holding in *Roger S.* involved a *public* mental hospital. Different (and lesser) procedural protections, established by statute, are available to children age 14 or older placed by a parent in a *private* facility. The child must be admitted with a diagnosis of either a mental disorder or a mental disorder plus a substance abuse disorder. If the child is age 14 or older and requests it, he or she is entitled to an *independent clinical review* by a neutral mental health professional. The review must be held within five days of the child's request. To authorize any further confinement and treatment of the child, the independent evaluator must confirm a diagnosis of mental disorder and find that (1) further inpatient treatment is likely to benefit the minor, and (2) placement in the facility represents the least restrictive, most appropriate setting. The child has a right to the assistance of a legal advocate at the review.[75]

This independent clinical review (sometimes called an "SB 595 hearing" because of the original bill number in the Legislature) represents a compromise between mental patients' advocates concerned about the well-documented misuse of private mental health facilities to confine "out-of-control" but not mentally ill adolescents[76] and mental health professional and hospital associations anxious not to discourage parents from seeking needed mental health care. As a result, the independent clinical review is very different from the traditional adversarial model used for LPS certification or capacity hearings. The emphasis is on the *clinical* appropriateness of the hospitalization. The neutral decision-maker is a mental health professional rather than a judge or hearing officer trained in law. He or she must be a licensed psychiatrist with training and experience in treating adolescent patients and have no direct financial relationship with the treating physician or the facility. The clinical reviewers are assigned on a rotating basis from a list approved by the county mental health director. Perhaps most important, the reviewing mental health professional, in addition to hearing testimony from the child and argument from the child's advocate, has the opportunity to interview the child.[77]

If the independent clinical reviewer determines that the criteria for continued hospitalization have not been met, the child must be released from the facility that same day. If the reviewer confirms that continued hospitalization is appropriate, the child can also seek *judicial review* through a petition for writ of habeas corpus.[78] Typically a patients rights advocate represents the child at the clinical review hearing, a court-appointed lawyer at the habeas corpus hearing.[79]

OTHER PROCEEDINGS

An advocate or attorney may represent a child in administrative or judicial proceedings to obtain benefits keyed to the child's mental disability, such as special education or disability benefits. These are not formally considered "mental disability proceedings." The federal Individuals With Disabilities Education Act (IDEA)[80] establishes for all eligible children a right to a free and appropriate public education. A child with disabilities is entitled to an Individualized Education Plan (IEP) designed to help him or her benefit from education. The child may be entitled to a broad spectrum of "related services," including counseling, transportation, and occupational therapy (to enable him or her to benefit from public education, as well as "transitional services" (to help make a successful transition from school to work, college, and independent living).[81] A

child with disabilities may be entitled to a range of other public benefits, such as social security disability benefits, Medicaid, and Early Periodic Screening Diagnosis and Treatment (EPSDT) services, to obtain placement and services that can enable him or her to live outside an institution.[82] A lawyer/advocate may represent the child and parents in seeking these benefits for the child, first exhausting administrative remedies and then, if necessary, pursuing judicial relief.[83]

A lawyer/advocate representing the child in another context, such as dependency or juvenile court, may also pursue special education benefits or other public benefits for the child client as part of developing an appropriate disposition. Inadequate screenings and a lack of coordination of services frequently result in the failure to provide appropriate services for abused and neglected children with disabilities. Various studies show that substantial percentages of children in out-of-home care are developmentally delayed or have serious psychological disorders.[84] Lawyers/advocates therefore may have to become "case managers" for their clients. A skilled advocate who understands the laws governing the various agencies that may have responsibility for serving the child can use the laws to the child's advantage and weave together a beneficial program of services.[85]

As one commentator aptly puts it, in the juvenile justice system, "[t]he assumption that children with emotional disabilities are either bad children who need to be punished or sick children who need medical treatment has impeded the development of effective special education and related services for this group of children."[86] Yet by bringing to the court's attention the services available to the child under special education and disability benefit law, lawyers may be able to prevent inappropriate placement in secure juvenile corrections facilities, detention centers, and mental hospitals.[87]

Finally, a lawyer representing a mentally disabled child in a family law custody dispute[88] may need to explore and pursue special education or disability-related benefits to support the client's ability to live in the desired custody arrangement. Whether the custody dispute is eventually resolved judicially or through mediation,[89] the child's lawyer can help the decision-making process by introducing this essential information.

LEGAL AND ETHICAL ISSUES WHEN THE CLIENT MAY BE DOUBLY IMPAIRED BY DISABILITY AND MINORITY

As discussed earlier, California provides legal counsel and advocacy for children in a variety of mental disability proceedings. Nevertheless, as the American Bar Association has noted, "Even when children are represented, the representation they receive is sometimes inadequate. Children's cases are often 'processed,' not advocated, and too frequently children's interests are poorly represented."[90] Similarly, studies consistently show inadequate representation by lawyers in mental disability commitment proceedings. Lawyers often defer to the state psychiatrist testifying, doing minimal or no cross-examination; do not perform even rudimentary investigation into the facts leading to the commitment petition; or do not explore alternatives to hospitalization.[91]

One study of attorneys representing children in protection proceedings found that most had no beneficial effect on case outcome. However, those who were effective differed from the rest in that they spent more time on their cases and "*displayed more independence in their role* as the child's advocate."[92] (Italics added.) Lawyers or advocates who lack a strong sense of their own role and ethical duties cannot take such independent action.

The extensive literature on representation of child clients[93] as well as on mentally disabled clients describes a common problem of "rolelessness."[94] Rolelessness refers to the confusion experienced by many lawyers/advocates who are unsure about how to carry out their professional obligations to a client who is mentally disabled or who is a child. A client's mental disabilities may be confusing and even frightening to a lawyer/advocate:

> Lawyers are likely to share the general public's unease with people with mental disabilities. A client who cannot readily perform the analytical and decision-making functions that are presumed to be part of the lawyer-client relationship can frustrate the lawyer. A client who has a hard time concentrating on the lawyer's questions because she is hearing voices or is deeply depressed may be frightening.
>
> A client's behavior, demeanor and decisions may vary from day to day as a result of mental disability, or because of the effects of medication. Clients with mental disabilities can be unpredictable in court; their testimony on the stand or behavior at a hearing can be completely unrelated to what they said or did in an interview with the lawyer earlier the same day. All this may be especially unsettling to a lawyer, since one of the attractions of the legal profession is its aura of rationality and control.[95]

Lawyers raise similar concerns about representing a child client:

> [T]he rules [of ethics] instruct lawyers to consult with their clients, to keep their clients informed, and to preserve their clients' confidentiality. But they do not explain how to perform this counseling function for children who have not sought or selected the lawyer, who do not understand the lawyer's function and for whom the

> legal process is unfamiliar, who … distrust adults, and for whom access to the lawyer, by telephone or in person, is restricted. The rules do not explain how to respond to a child client's age, dependency, lack of verbal ability, or severe medical needs.[96]

Of course, when the client is a child as well as mentally disabled, the difficulties are doubled:

> The issue of control over the conduct of a case is often difficult, especially in juvenile [delinquency] cases when the attorney's willingness to acquiesce to his or her client's wishes is tempered by the fact that the client is a child who is immature, poorly educated, unsophisticated, and, all too frequently, emotionally disturbed or somehow physically, mentally or emotionally handicapped.[97]

A second important factor contributing to rolelessness is the culture of the forum within which the lawyer/advocate practices. Courts that routinely hear mental health matters develop a special subculture within which lawyers are only accepted if they learn and follow the informal procedure and unwritten rules.[98] Similarly, juvenile and dependency courts develop a certain distinct culture, and lawyers practicing in this culture feel pressure to conform.[99] Within this culture, a lawyer/advocate may be encouraged to avoid the traditional adversarial role and to share the general conviction that the client is of course "sick" or "needs help."[100] Judges or hearing officers and other court personnel may encourage the lawyer/advocate to decide what is in the client's best interest rather than advocate for the client's expressed wishes or vigorously enforce the client's due process rights.

In order to resist such pressures, lawyers/advocates representing children in mental disability proceedings must have a strong and well-developed idea of their role. They must understand their professional duties to their clients under the traditional view of the lawyer's role as well as the extent to which that role can be modified to reflect the clients' special needs.

MODEL CODE AND RULES AND THE TRADITIONAL VIEW

The traditional view of the lawyer's role and obligations is found in the American Bar Association's Model Code of Professional Responsibility[101] and the Model Rules of Professional Conduct.[102] Canon 7 of the Model Code states: "A lawyer should represent a client zealously within the bounds of the law."[103] In general, the lawyer's responsibility is to pursue the client's interests—as the client defines them—as long as the client does not ask the lawyer to break the law or violate the canons of ethics. The lawyer can consult with the client about both the client's goals and the means by which they are pursued[104] and "limit the objectives of the representation if the client consents after consultation."[105] But both the Model Code and the Model Rules assume that the client has control over the fundamental decisions in the case. The Ethical Considerations (EC) accompanying the canons of the Model Code explain that a lawyer can make decisions only as to matters "not affecting the merits of the cause or substantially prejudicing the rights of a client."[106] Otherwise, the client has *exclusive* authority to make decisions, and the decisions are binding on the lawyer.

Traditionally, the attorney is to act as both the client's advocate and counselor. The lawyer/advocate must first provide the client with the information necessary for an informed decision. After providing this information, the lawyer/advocate's task is to assist the client in reaching a decision. This means helping the client identify goals and weigh the pros and cons of the proposed course of action, answering the client's questions, and expressing a professional opinion on the practical effect of the client's decision.[107] The lawyer's role is to facilitate the client's decision, not to make it for the client.[108]

It is quite consistent with the concept of client autonomy for a lawyer to make a recommendation, as long as the client is free to accept or reject it. In counseling the client, the lawyer

> may emphasize the possibility of harsh consequences that might result from assertion of legally permissible positions. In the final analysis, however, the lawyer should always remember that the decision whether to forego legally available objectives or methods because of nonlegal factors is ultimately for the client and not for himself.[109]

Throughout the course of representation the lawyer may continue to recommend that the client rethink his or her goal. The lawyer may also withdraw from representation if the client insists upon a course of action that violates the lawyer's moral or personal standards.[110] However, in representing the client to the outside world, the lawyer must speak for the client as if the lawyer had no doubts about the merits of the client's position.

THE TRADITIONAL VIEW AND THE CLIENT UNDER DISABILITY

Both the Model Rules and Model Code assume client competency—that in most cases the client will be able to understand the information and advice provided by the lawyer, to make decisions, and, finally, to communicate those decisions to the lawyer.[111] However, Model Rule 1.14 recognizes that there may be instances in which "a client's ability to make adequately considered decisions in connection with the representation is impaired, whether

because of minority, mental disability or for some other reason ...."[112] This "Client Under a Disability" rule identifies both minority and mental disability as possible forms of disability. "Minority" can simply refer to a child client's *legal disability:* the common law or statutory requirement that a minor can take legal action—for example, sue or be sued—only through a parent or guardian ad litem. It can also suggest that, simply because of the client's young age and degree of development, he or she is in fact incapable of making decisions regarding legal action. The first type of incapacity is *de jure*, the second *de facto*. Model Rule 1.14 makes no distinction between them.

If a client is unable "to make adequately considered decisions," how does that affect the lawyer's responsibilities and role? If a client has a legal guardian or other court-appointed representative such as a conservator, the lawyer ordinarily informs and advises that representative and takes directions from him or her. But this is likely to be the case only where the client is pursuing or defending a civil action filed against him or her and involving another private party—an inheritance claim or a tort suit, for example. By contrast, where the state seeks to restrict the client's liberty, either in a civil or criminal proceeding, the conservator or legal guardian usually does not direct the court-appointed counsel. Thus, in proceedings to establish or renew a conservatorship, the proposed conservatee instructs the counsel,[113] and in juvenile court proceedings the child directs his or her counsel.[114]

The Ethical Considerations to the Model Code (Canon 7, EC 7-12) indicate that if a client under disability has *no* legal representative,

> his lawyer may be compelled in court proceedings to make decisions on behalf of the client. If the client is capable of understanding the matter in question or of contributing to the advancement of his interests, regardless of whether he is legally disqualified from performing certain acts, the lawyer should obtain from him all possible aid. If the disability of a client and the lack of a legal representative compel the lawyer to make decisions for his client, the lawyer should consider all circumstances then prevailing and act with care to safeguard and advance the interests of his client. But obviously a lawyer cannot perform any act or make any decisions which the law requires his client to perform or make, either acting for himself if competent, or by a duly constituted representative if legally incompetent.[115]

This instruction gives the lawyer conflicting advice. On the one hand, the client's mental disability alone does not relieve the lawyer of the responsibility to attempt to inform or advise the client and to obtain from the client "all possible aid" in determining the client's wishes. The Model Code thus does not authorize the lawyer to make decisions based upon the lawyer's, rather than the client's, definition of the client's interests. Yet the Model Code also indicates that, at least when representing a client in court proceedings, the lawyer can make *some* of the kinds of decisions ordinarily reserved for the client. In so doing the lawyer must "safeguard and advance" the interests of the client.

Can an attorney who believes that the client is not competent to advise or direct the course of representation simply ask the court to appoint a guardian ad litem? To do so may violate the admonition to "act with care to safeguard and advance the interests" of the client.[116] Telling the court that one's client is incompetent and asking for a guardian ad litem to be appointed essentially concedes the merits of a conservatorship petition or of a hearing to determine the client's ability to consent to or refuse treatment. The Commentary to Model Rule 1.14(b) acknowledges this danger:

> [D]isclosure of the client's disability can adversely affect the client's interests. For example, raising the question of disability could, in some circumstances, lead to proceedings for involuntary commitment. The lawyer's position in such cases is an unavoidably difficult one. The lawyer may seek guidance from an appropriate diagnostician.[117]

Technically, a "diagnostician" can provide a "diagnosis" of the client's mental condition, but the diagnosis may not be especially helpful to the lawyer. There is no automatic correlation between any given diagnosis and incompetency as a matter of law.[118] A client with a mental disability may still possess "the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being."[119] Even a legally incompetent client may be "capable of understanding the matter in question or of contributing to the advancement of his interests."[120] What the lawyer really needs to know is how to understand and communicate as effectively as possible with the client given the client's disability. While the lawyer "may seek the appointment of a guardian or take other protective action with respect to a client," Model Rule 1.14(b) cautions that this can be done "only when the lawyer reasonably believes that the client cannot act in the client's own interest."[121] This rule would certainly apply to a situation where communication is totally lacking—for example, because the client just stares into space and does not respond to or acknowledge the lawyer's presence.[122] In such a case, it would be ethical for the lawyer to petition for appointment of a guardian ad litem or simply indicate to the court that he or she had been unable to communicate with the client.

But this example of a severely impaired client is distinguishable from one where the client wishes to resist the appointment of a conservator or refuse proposed treatment and communicates this clearly to the lawyer/advocate. Just because the client shows evidence of delusional thinking or behaves in ways suggesting mental disability does not mean the lawyer is justified in seeking appointment of a guardian ad litem. Rule 1.14(a) requires that "the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the [mentally disabled] client." The comment to the rule states that even "a client lacking legal competence often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being."[123] The fact that a client may be disabled "does not diminish the lawyer's obligation to treat the client with attention and respect."[124]

Even if a client already has a guardian or other legal representative, the lawyer still has a duty to maintain communication with the client. Realizing that the guardian ad litem is not the client—only someone appointed to facilitate the lawyer's representation of the client—is critical. If the lawyer becomes aware that the guardian "is acting adversely to the [mentally disabled client's] interest," he or she may be required to prevent or rectify the guardian's misconduct.[125] This could mean asking a court to review the appropriateness of the guardian's actions, to appoint a different guardian, or even to reconsider the need for a guardianship. Thus, appointing a guardian for a mentally disabled client does not resolve the lawyer's ethical dilemma completely.

Can or should the attorney act like a guardian ad litem—decide what is in the client's best interest and pursue that goal, rather than advocating the client's expressed desires? Such an approach is fundamentally at odds with the principles underlying the Model Code and Model Rules and was explicitly rejected by both judges and legislatures before the Model Rules were drafted.[126] "But," notes EC 7-12, "obviously a lawyer cannot perform any act or make any decisions which the law requires his client to perform or make …."[127] If a client is in fact incompetent, he or she may need a guardian to be appointed. But the lawyer who simply takes on the role of guardian without being appointed by a court violates the client's legal right to make decisions unless and until he or she declared incompetent by an appropriate authority.

In contrast, by advocating for the client's expressed wishes, the "attorney avoids the psychiatric trap of trying to determine what the client 'really' wants,"[128]—a task for which he or she is not professionally trained. By zealously presenting the client's expressed desires and point of view the lawyer performs a unique professional role:

> [T]he client is frequently in the position of being treated as a nonperson. Often poor and confused, the client has had his or her ability to think and function impugned. There are usually doctors, nurses, investigators, and conservators aligned against the individual, none of whom will express the client's story or goals in court. If the attorney will not do so, the individual's side remains unrepresented.[129]

The established role of the lawyer should not suddenly be changed without warning to the client. A person with a mental disability, just like other clients, is entitled to expect that his or her lawyer will "act like a lawyer" and will not suddenly become a guardian ad litem—a would-be therapist or the unappointed judge of the merits of the client's case. A lawyer who changes roles in this way violates an ethical duty of loyalty to the client.

It is ethically unacceptable for a lawyer, representing an *adult* mentally disabled client, to act like a guardian ad litem. Is it any different when the client is not only mentally disabled but a child? Two ABA model codes for representing child clients—and the recommendations of the Fordham Conference[130]—address this complex issue.

STANDARDS FOR REPRESENTING CHILD CLIENTS

The ABA has promulgated standards over the years to ensure quality representation for child clients. These standards address issues arising in both delinquency and dependency proceedings.

IJA–ABA Juvenile Justice Standards

The Juvenile Justice Standards Related to Counsel for Private Parties, promulgated by the American Bar Association/Institute of Judicial Administration Joint Commission on Juvenile Justice (IJA–ABA),[131] provide guidance to lawyers representing children charged with status offenses or delinquent acts in juvenile court.[132] According to the IJA–ABA Standards, where a juvenile client is capable of "considered judgment," the determination of the client's interest is his or her responsibility.[133] The standards reject any assumption of identity of interest between the state and the accused child. They leave it within the power of the client, after consultation with the attorney, to decide whether, in his or her particular case, such identity exists[134] and thus whether it would be in the client's best interest to, for example, waive the right to trial. The standards also provide that the child client capable of "considered judgment" can authorize disclosure of confidential lawyer-client communications.[135]

The term "considered judgment" does not necessarily mean that the juvenile client can accurately weigh all the costs and benefits of available options. The IJA–ABA

Standards note that it is "ordinarily sufficient that clients understand the nature and purposes of the proceedings and its general consequences and be able to formulate their desires … with some degree of clarity. Most adolescents can meet this standard, and more ought not to be required of them."[136]

What if a child client is not fully capable of "considered judgment"? Does this mean that the lawyer can assume a guardian ad litem role? The standards explicitly reject this proposition:

> Where a client's capacity may be affected by extreme youth, mental disability, or other cause … such difficulties only underline the attorney's duty to seek effective communication and consultation with the juvenile and do not justify adoption of a "guardian" … role.[137]

In such a situation, should the lawyer ask for a guardian ad litem to be appointed? The IJA–ABA Standards permit the lawyer to request appointment of a guardian, but recommend that the attorney consult the juvenile client as well as any appointed guardian concerning essential matters.[138] When the client and guardian substantially disagree about the client's best interest, the attorney may so inform the court.[139] As discussed earlier, in a situation where the alleged inability of the child to make reasoned judgments in his own best interest is the essence of the charge against him, the attorney's action in requesting a guardian may be tantamount to a concession on the merits.[140]

The IJA–ABA Standards emphasize three key concepts: the child's need for legal counsel at key stages of the juvenile justice process; the lawyer's obligation to consult the child, as one would an adult client, on essential matters and to honor the client's decision; and the lawyer's duty to protect the rights of the client of limited or uncertain competency as vigorously as one would defend those of any other client.[141] The standards assume that "most adolescents" will be capable of the "reasoned judgment" needed to competently instruct their counsel. Most of the child clients in juvenile court are indeed adolescents because age 12 is typically the point at which juvenile codes establish jurisdiction over status offenders and delinquents.[142]

The IJA–ABA Standards may be less helpful for lawyers representing children under age 12 in dependency court. The ABA Standards for Child Abuse and Neglect Cases (hereinafter Child Abuse and Neglect Standards)[143] address the problem posed when an attorney's clients range in age from one day old to late teens.

ABA Standards for Child Abuse and Neglect Cases

The Child Abuse and Neglect Standards, adopted in 1996, build upon the IJA–ABA Standards. Like the IJA–ABA Standards, they affirm the traditional view of the lawyer-client relationship. The child's attorney "owes the same duties of undivided loyalty, confidentiality and competent representation to the child as is due an adult client."[144] The standards refer to Model Rule 1.14(a) and prescribe that, "[i]n all but the exceptional case, such as with a preverbal child, the child's attorney will maintain this traditional relationship with the child client."[145] Although in many, perhaps most, cases the attorney for the child will be appointed by the court, the standards clearly state that even privately retained counsel represent the child client, not the person paying for the legal services.[146]

Consistent with the traditional view, the lawyer has a duty to advocate the client's articulated position rather than the lawyer's opinion about what would be in the best interest of the child. The standards provide that the child's attorney should "represent the child's expressed preferences and follow the child's directions throughout the course of litigation."[147] This is necessary "to ensure that the child's independent voice is heard."[148]

If the child cannot express a preference, the attorney may not simply advocate his or her own view of the child's best interest. Rather, the attorney "shall make a good faith effort to determine the child's wishes and advocate accordingly or request appointment of a guardian ad litem."[149] If the child client "does not or will not express a preference about particular issues, the child's attorney should determine and advocate the child's legal interests."[150] The standards distinguish the attorney's role, identifying the child's *legal* interests, from the guardian ad litem's role, deciding what is in the child's *best* interest:

> The determination of the child's legal interests should be based on objective criteria as set forth in the law that are related to the purposes of the proceedings. The criteria should address the child's specific needs and preferences, the goal of expeditious resolution of the case so the child can remain or return home or be placed in a safe, nurturing, and permanent environment, and the use of the least restrictive or detrimental alternatives available.[151]

The Child Abuse and Neglect Standards emphasize that the lawyer, in determining the client's legal interests, should *not* do so based "merely on the lawyer's personal values, philosophies, and experiences."[152] Nor should the lawyer decide based upon what he or she believes to be true about children in general. "Individual children have particular needs, and the lawyer must determine the child client's individual needs."[153]

Under the standards, the attorney has the responsibility to determine whether the child client is "under a disability" within the meaning of Model Rule 1.14. Significantly, the standards reject a "global" approach under which a child

client is either fully competent and therefore entitled to zealous representation under the traditional model or is completely incompetent. The standards

> do not accept the idea that children of certain ages are "impaired," "disabled," "incompetent," or lack capacity to determine their position in litigation. Further, these Standards reject the concept that any disability must be globally determined. Rather, disability is contextual, incremental, and may be intermittent. The child's ability to contribute to a determination of his or her position is functional, depending upon the particular position and the circumstances prevailing at the time the position must be determined. Therefore, a child may be able to determine some positions in the case but not others. Similarly, a child may be able to direct the lawyer with respect to a particular issue at one time but not at another. This Standard relies on empirical knowledge about competencies with respect to both adults and children.[154]

The lawyer must make every effort to identify and understand the needs and desires of the individual child client, even if the child cannot or will not articulate them directly. "Even nonverbal children can communicate their needs and interests through their behaviors and developmental needs."[155] It is not sufficient for the lawyer merely to present information to the court in an amicus curiae role: "The child's attorney should not be merely a fact-finder, but rather, should zealously advocate a position on behalf of the child."[156]

Among the lawyer's basic obligations is to *counsel* the child client concerning the subject matter of the litigation, the child's rights, the court system, the proceedings, the lawyer's role, and what to expect in the legal process.[157] As part of this counseling function, as with any client, the lawyer may express his or her assessment of the case, the best position for the child to take, and the reasons underlying the recommendation.[158] The child's attorney may counsel against the pursuit of a particular position sought by the child.[159]

In doing so, however, the standards caution the attorney to be especially aware of the danger of intimidating and manipulating the child client. A child client may be more susceptible than some adult clients to domination by the lawyer because of "the power dynamics inherent in adult/child relationships."[160] Therefore, the child's attorney "should ensure that the decision the child ultimately makes reflects his or her actual position."[161]

What if the child client, far from deferring to the attorney's advice, insists on a course of action that, in the lawyer's view, is not in the client's best interest? In such a case the standards do not permit the attorney, purely on that basis, to request appointment of a guardian ad litem or to withdraw from representation. If he or she determines that the child's expressed preference would be *seriously injurious* to the child (as opposed to merely being contrary to the lawyer's opinion of what would be in the child's interest), the child's lawyer may request appointment of a separate guardian ad litem. However, the attorney must "continue to represent the child's expressed preference.… The child's attorney shall not reveal the basis of the request for appointment of a guardian ad litem which would compromise the child's position."[162]

The standards clearly do not endorse the lawyer's assumption of a guardian ad litem role. Indeed, they recognize that there is often an inherent conflict between the lawyer's duty to advocate the client's expressed position and the guardian's task of determining the best interest of the child. The standards acknowledge, but do not approve, the model used in some states in which a lawyer representing the child client is also appointed as guardian ad litem. In such a case, if the lawyer determines performing both roles causes a conflict, the lawyer should continue to perform as the child's attorney and withdraw as guardian.[163] The standards take the optimistic view that, "[a]s a practical matter, when the lawyer has established a trusting relationship with the child, most conflicts can be avoided. While the lawyer should be careful not to apply undue pressure to a child, the lawyer's advice and guidance can often persuade the child to change an imprudent position or to identify alternative choices if the child's first choice is denied by the court."[164] Still, "the lawyer has a duty not to overbear the will of the child. While the lawyer may attempt to persuade the child to accept a particular position, the lawyer may not advocate a position contrary to the child's expressed position except as provided by these Abuse and Neglect Standards or the Code of Professional Responsibility."[165]

The exception permissible under the standards occurs where a substantial danger to the child client is revealed to the lawyer in a confidential disclosure. In such a situation the lawyer may request appointment of a guardian ad litem while continuing to represent the child. However, this action may not adequately protect the child. Therefore, "where there is a substantial danger of serious injury or death … the lawyer must take the minimum steps which would be necessary to ensure the child's safety, respecting and following the child's direction to the greatest extent possible consistent with the child's safety and ethical rules."[166]

The standards' exception is much narrower than, and distinguishable from, the recently adopted California rule, applicable only in dependency court proceedings, under which the child's attorney's "primary responsibility" is to "advocate for the protection, safety, and physical and emotional well-being of the child."[167] Although counsel

for a child 4 years or older must "advise the court of the minor's wishes … *[c]ounsel for the minor shall not advocate for the return of the child to the parents if, to the best of his or her knowledge, that return conflicts with the protection and safety of the minor.*"[168] (Italics added.) The California rule requires the child's attorney in virtually every child abuse or neglect case to make predictions about future danger to the child—an area in which lawyers are not professionally trained and can claim no special expertise. The California rule does not assume that the attorney has any more information about the child's circumstances than what is available in the court record. In essence the rule requires the child's attorney to perform the same function as the judge: to determine whether the child can be safely returned to the custody of a parent.

By contrast, the Abuse and Neglect Standards' exception applies only in the rare circumstances where the attorney, by virtue of his or her confidential relationship with the child client, becomes aware of a danger to the client. There must be "substantial danger of serious injury or death" to permit the lawyer to take any action to protect the child. Even then, the exception does not explicitly authorize the lawyer to advocate against the child client's expressed position—for example, by informing the court that the attorney believes the child would be endangered if returned to the parent's custody. The language of the standards possibly would permit such an action by the lawyer, assuming that this was "the minimum step … necessary to ensure the child's safety." Moreover, the attorney still must follow the child client's directions to the greatest extent possible.

Finally, the ABA Child Abuse and Neglect Standards emphasize the lawyer's duty to look beyond the specific issue raised in the initial legal proceeding, to identify the child client's needs and explore the resources available to meet them. "The lawyer must also identify appropriate family and professional resources for the child, including counseling, educational and health services … and other forms of material assistance for which the child may qualify under law."[169] Significantly, the standards instruct the lawyer to do so, not from a guardian ad litem's perspective of "what would be good for this child," but to the extent such action is consistent with the child's wishes.[170] The standards recognize that maximizing resources is especially important when representing a child with mental or physical disabilities: "*Consistent with the child's wishes*, the child's attorney should assure that a child with special needs receives appropriate services to address the physical, mental, or developmental disabilities."[171] (Italics added.) Assuming that such a course is consistent with the lawyer's professional duty to the child client, he or she may request court authorization to pursue these services for the client.[172]

Effective legal representation can be done only by lawyers/advocates who have a clear understanding of their professional obligation to their clients, as well as the training and expertise to carry it out.

FORDHAM CONFERENCE RECOMMENDATIONS

The recommendations developed by the participants in the Fordham Conference on Ethical Issues in the Legal Representation of Children[173] were designed to build upon the IJA–ABA Juvenile Justice Standards and the ABA Child Abuse Standards. The recommendations endorse many of the general principles set out in those standards but also critically address the ways in which the standards were insufficient and suggest improvements.[174] The recommendations focus on seven areas of concern, including (1) allocation of decision-making authority between child client and attorney; (2) assessment of the child's capacity to make decisions in the representation; and (3) the lawyer's role as decision-maker when the child cannot direct the representation.[175]

The recommendations strongly endorse the principle that the lawyer for a child client should function in the traditional role rather than as a guardian ad litem: "The lawyer should assume the obligations of a lawyer, regardless of how the lawyer's role is labeled. The lawyer should not serve as the child's *guardian ad litem* or in another role insofar as the role includes responsibilities inconsistent with those of a lawyer for the child."[176] Consistent with this position, the lawyer for a child who has the capacity to direct the representation "must allow the child to set the goals of the representation as would an adult client."[177] As with an adult client, the lawyer has an ethical duty "to advocate the position of a child unless there is independent evidence that the child is unable to express a reasoned choice."[178] If the child client has indeed made a "reasoned choice, even if the attorney or other adults might disagree with the choice, the attorney nonetheless is bound by" it.[179]

The recommendations identify three groups of child clients: the client who is not impaired (who has full capacity to direct the representation); the client who is verbal but impaired (who can communicate with the lawyer but who is not fully capable of "reasoned choice"), and the preverbal client (who is unable to communicate with the attorney). The lawyer has the duty to determine whether the child client has the capacity to express a reasoned position (and thus to direct the representation).[180] In assessing the client's competency the lawyer "should seek guidance from appropriate professionals and others including family members"[181] and should consider factors including the child's developmental stage, ability to articulate reasons

and communicate with the lawyer, and ability to understand consequences.[182] Noting that "[n]othing about legal training or traditional legal roles qualifies lawyers to make decisions on behalf of their client,"[183] the recommendations state that "[an] attorney *with background and training in child development* should decide whether the child is sufficiently able to set the goals of the litigation and direct the representation."[184] (Italics added.) Although seeking the assistance of a mental health professional or social worker may be helpful for the lawyer, in assessing the client's competency "mental health professionals should not determine capacity because this term constitutes a *legal* construct and involves making a *legal* determination."[185] (Italics added.)

The lawyer "must presume the child client's capacity."[186] "Because of the nearly irresistible instinct to conclude that the child client is competent only where the attorney agrees with his or her expressed preference," the recommendations require "the lawyer to separate out the evaluation of the client's ability to make a decision from the lawyer's evaluation of the decision itself."[187] "The lawyer should not decide that the client lacks capacity simply because he or she feels the client is exercising poor judgment."[188] In evaluating the client's capacity, the lawyer should be aware of his or her own biases and become educated about the role culture, race, ethnicity, and class may play in the choices a child client may make.[189] Competency does not depend upon the content of the child's decision but on how he or she arrived at the decision.[190] The lawyer should "focus on the child's ability to articulate a well-reasoned, independent choice, with a true understanding of the consequences involved."[191] The lawyer should also consider whether the child is consistent in expressing his or her wishes and whether the decision contradicts or reinforces the client's other decisions or expressed wishes.[192]

The lawyer must act upon and carry out a child client's "well-reasoned … rational decision" even when it may threaten the child's life or result in death. The recommendations do not "deny capacity to children who make life-threatening decisions."[193] Although the recommendations permit a lawyer to exercise discretion and abrogate the traditional role "when an immediate danger threatens the child's life," this exception applies only with an *impaired* client.[194] An attorney who believes that a previously competent client has become impaired must meet "an extremely high threshold" of proof to justify a change in the traditional lawyer-client relationship.[195]

Even if the lawyer determines that a child client *is* impaired, he or she cannot automatically abrogate the traditional role or assume the function of a guardian ad litem. Rather, the lawyer "must engage in additional fact finding to determine whether the child may develop the capacity to direct the lawyer's action." It is the lawyer's duty "to recognize, facilitate, and maximize the child's capacities."[196] If impairment results from a physical or mental disability, learning more about the disability "may help a lawyer to understand the reasoning of a child client, or may alert the lawyer to an additional need to facilitate the child client's communication."[197]

The recommendations recognize that a child client "might be unimpaired as to some types of decisions and impaired as to other decisions within one case." Thus the lawyer for a verbal but impaired child "must solicit input from the child insofar as the child can give meaningful input."[198] The weight given to a child's expressed opinion falls on a "sliding scale," to be determined by the attorney, in consultation with experts as needed. If the child client is competent to make a particular decision, the lawyer must carry out the client's expressed wishes on that decision. Only where the lawyer finds that the child is not competent regarding a particular decision can the lawyer exercise discretion and use the "sliding scale."

Because the lawyer for a verbal but impaired child client may deviate from the traditional lawyer role, he or she must inform the client about this possibility. The recommendations suggest that the lawyer tell the verbal but impaired child client "she cannot promise to do everything that the child wants, but she can promise to listen to the child's views and carry out the child's wishes when she thinks the child is able to make that particular decision."[199] Similarly, with regard to confidentiality, the attorney must inform a child client of any limitation on his or her promise to keep what the child client says confidential—for example, if the attorney has an ethical obligation to disclose client communications to protect the child from immediate, serious harm.[200]

As to the final category, the preverbal child client, the recommendations express "a consensus that lawyers for children currently exercise too much discretion in making decisions on behalf of their clients including 'best interests' determinations."[201] To avoid this danger, lawyers for a preverbal client should still not assume the guardian ad litem role[202] but should try to "arrive in a principled way at a position or a range of positions which they may present to the fact finder or decision maker."[203] The lawyer representing a preverbal or impaired child client must identify not the "best interest" but the *legal* interests of the child.[204] A *legal* interest is any interest that the legal proceeding has authority to address, including, for example, a right to "appropriate education" or placement in the "least restrictive alternative," as well as interests in procedural due process rights.[205]

In identifying the client's *legal* interests, the lawyer should "focus on the child in her context,"[206] to achieve "a

thickly detailed view of the child client as a unique individual."[207] The lawyer's responsibilities must include talking with the client, in a "dynamic and evolving" process throughout the course of the case.[208] "Even where the lawyer has determined that the child cannot fully understand or express desires about the case, there will be very few verbal children who cannot express some views about their own lives."[209] The lawyer must consider all legally available options, including good-faith options for seeking modification of the law.[210] If the lawyer cannot narrow down the options to one preferable course of action, he or she must identify the client's *primary* legal interest and present it to the court. However, the lawyer must also present evidence "on the remaining options to the court, and in opposition to all options that were actually available but that have been eliminated from the child's legal interest."[211]

Where needed, lawyers for the preverbal or impaired client can retain experts to aid them in deciding which legal interests to pursue. When lack of resources make such consultation impracticable, the lawyer may look to experts already involved with the client. However, he or she should be aware that these experts do not share the attorney's duty of advocacy and may have conflicting obligations.[212] Similarly, recognizing the possible conflicts of interest, lawyers for preverbal clients should "advocate vigorously to protect the child's basic needs including medical and mental health services, housing, education, nourishment and strong agency case planning and implementation." At the same time, however, they should "challenge the basis for experts and agency conclusions in order to ensure accuracy" and strive to make sure that the child client's receipt of services is consistent with the position taken and goals pursued on behalf of the child.[213]

The Fordham Conference recommendations also suggest the addition of state law mandating "that lawyers … be appointed to represent children in … mental health commitment cases."[214] The recommendations are an especially helpful source of ethical guidance for the lawyer representing a child in such proceedings. The lawyer can first use the recommendations concerning competency to identify whether an individual child client is fully capable, verbal but impaired, or preverbal. Having done so, the lawyer next must either carry out the expressed wishes of the competent client or refer to the guidelines regarding his or her representation of verbal but impaired or preverbal clients. Consistent with the recommendations, the lawyer should not assume that a mental disability automatically renders a child client incompetent. Moreover, the lawyer should evaluate competency based upon *how* the client reaches a decision, not depending upon whether the lawyer agrees with the decision. A competent client's decision—for example, to give or withhold consent to treatment—must be honored, even if, in the lawyer's opinion, it may be inconsistent with the client's best interest. Even if a mentally disabled child client is verbal but impaired, the recommendations still require the lawyer not only to consult the client but also to maximize the client's ability to participate in the determination of his or her legal interests. The lawyer may not assume a guardian ad litem role, even for a preverbal client, but must strive to identify the client's legal interests and present all reasonable options to the court. The lawyer can and should make use of mental health professionals and other experts in assessing the child client's competency or determining the client's legal interests; however, he or she cannot delegate to others the *legal* and professional decisions only a lawyer can make.

THERAPEUTIC JURISPRUDENCE

Can or should the lawyer modify his or her representation of the child client because doing so is more "therapeutic"? Critics of traditional legal advocacy in mental health proceedings have charged that this harms the mentally disabled person's relationships with mental health professionals and family members:[215] it is counter-therapeutic, undermines trust in the mental health system, encourages refusal of treatment, and makes court proceedings unnecessarily stressful.

Nevertheless, research on the therapeutic impact of civil commitment proceedings and access to legal representation does not support the criticisms.[216] On the contrary, mentally disabled persons' perception that they have been coerced may affect their attitude toward and compliance with treatment.[217] Thus, providing full due process protections and effective legal counsel may well be therapeutic by "visibly demonstrat[ing] a coherence between the decision-making process and the mandates of the law so that justice 'is seen to be done.'"[218] A mentally disabled person who believes that he or she has been fairly treated is more apt to accept the ruling of the committing court and comply with the treatment plan.[219] "Enhancing respect for authorities, the willingness to voluntarily accept the decisions of authorities, and the willingness to follow social rules are core objectives to any therapeutic program."[220] A similar argument has been made that providing due process in juvenile court will encourage young offenders to trust the system and cooperate in their rehabilitation.[221]

Unfortunately, most discussions of the "therapeutic" impact of legal advocacy assume that the client is mentally disabled and that the most "therapeutic" outcome is for the client to accept that he or she is mentally disabled,

cooperate with the treatment plan, and submit to the authority of the mental health profession and the court. Providing full due process protections and legal representation is thus "therapeutic" because it will encourage such an outcome. But what if the client is not mentally disabled, or if the treatment plan is inappropriate, or the mental health and legal systems are "dysfunctional"?[222] In such a case, acceptance of the label of mental disability, compliance with treatment, or submission to authority might be counter-therapeutic, while vigorous assertion of the client's legal rights would better promote his or her mental well-being. There may also be a conflict between what is "therapeutic" for the client and for other concerned parties, such as family members overwhelmed by the demands of caring for the child.

Several ethical standards suggest that lawyers consider therapeutic concerns when representing a client with a disability or a child client. For example, the Commentary to Model Rule 1.14 notes that an attorney who is considering whether to petition for appointment of a guardian ad litem must take into account that such an appointment "may be expensive or traumatic" for the client. Similarly, the ABA Child Abuse and Neglect Standards note, regarding whether the child client should testify, "While testifying is undoubtedly traumatic for many children, it is *therapeutic and empowering* for others." (Italics added.) The commentary further suggests: "The lawyer should also prepare the child for the possibility that the judge may render a decision against the child's wishes which will not be the child's fault."[223] The Fordham recommendations for representing the preverbal child direct the lawyer to "shield the child from jurogenic harm (*e.g.*, multiple interviews, multiple hearings, and delays)."[224]

Lawyers in family law practice can and should advise even an "unimpaired" adult client to choose the legal course of action beneficial to his or her mental health. If a client's emotional problems do impair his or her judgment, the lawyer should encourage the client to seek mental health counseling or treatment.[225] In general, "the attorney should attempt to convince the client to work toward family harmony or the interests of the children. Conduct in the interests of the children or family will almost always be in the client's long term best interests."[226]

The lawyer can also try to reduce the "nontherapeutic" aspects of the legal proceeding by fostering good relations with family members, mental health professionals, and court personnel. The Model Code requires the lawyer to "treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm."[227] The Matrimonial Lawyers Standards caution that the lawyer "should not do anything to increase the emotional level of the dispute."

The IJA–ABA Standards require the lawyer "to cooperate with social work and probation departments and to instruct the client to do so."[228] These standards recognize the practical benefit to lawyer and client of being on good terms with the people who have the power to make decisions affecting the client. However, there is an important condition: such cooperation is required unless it is inconsistent with promoting the client's legal interests.[229]

This brings the inquiry full circle: Who can or should make the decision about what legal course of action is "therapeutic"?[230] When a client's legal interests and therapeutic interests conflict, who can decide which to pursue? Based upon the earlier analysis of ethical standards, it seems clear that only a fully competent child client could make such a decision. A verbal but impaired child may be able to give the lawyer information about his or her desires but cannot waive a legal right—which is in effect what is done when one chooses to forego pursuit of a legal interest for "therapeutic" reasons. A preverbal child cannot inform or instruct the lawyer at all. Can the lawyer for a verbal but impaired or preverbal child decide to waive a legal interest in the client's "therapeutic best interest"? Such a waiver is, in my opinion, the kind of decision referred to under the Model Code that is not within the attorney's discretion and that only the client can make. The same reasons a lawyer is not qualified to and should not make "best-interest" decisions for the child client are even more compelling when "therapeutic" is added to the phrase.

Ultimately, the most "therapeutic" thing the lawyer can do is to empower[231] the child client. That means treating the client with respect and building trust, trying to understand and communicate effectively with him or her, and resisting the temptation to coerce the client's compliance. It means encouraging others involved with the child, including parents,[232] mental health professionals, and court personnel, to behave the same way. It means maximizing the client's understanding of and participation in legal or treatment proceedings by informing, listening, counseling, assisting in decision making, and expressing the client's unique individual perspective to the decision-maker. It means working to identify not just the legal issues involved in the immediate proceeding but also those that may be pursued in the future by or on behalf of the client.[233] Finally, it means affirming to the client and to the outside world the inherent value of that child. "In a system of law, the idea of rights, and the recognition that an individual has a right to something, is all but synonymous with a recognition that the person is worthy of respect. …The assistance of a lawyer/advocate affirms both the importance of the right and of the person."[234]

SPECIAL CONCERNS AND TRAINING FOR THE LAWYER/ADVOCATE

As has been noted earlier, professional ethics codes direct the lawyer to empower the child client by providing information and counseling and by helping him or her participate to the maximum extent possible in the course of legal representation. This section will discuss special concerns and additional obligations of legal counsel in mental disability proceedings. First, it will discuss the importance of identifying the client's and family members' attitudes about mental disability. Second, it will describe the temptation to act as a therapist rather than as an attorney and explain why this occurs and why the lawyer must resist it. It will suggest as a corrective that the lawyer look to the objective language of California mental health laws to help identify the legal interests of the child client. Finally, this section will suggest specialized training that will better qualify lawyers and advocates to provide high-quality legal representation in mental disability proceedings.

SPECIAL CONCERNS IN MENTAL DISABILITY PROCEEDINGS

The attorney in a mental disability proceeding must address issues that do not arise in other proceedings. First, the attorney must identify the family's perceptions of mental disability and then address these perceptions. Second, the attorney must ensure that he or she acts as the child's guardian ad litem rather than as a therapist.

Addressing the Client's and Family's Attitudes Toward Mental Disability

Whether the client is facing a decision to accept treatment on a voluntary basis or to seek public benefits, the lawyer/advocate cannot provide adequate counsel without first identifying how the client and his or her family perceive mental disability. Unfortunately, a diagnosis of mental illness or disability still carries a tremendous negative connotation in American society. As noted earlier, courts establishing due process rights for adults and minors facing civil commitment have recognized the stigma associated with mental disability, as well as the lifelong impact it can have on reputation, education, and employment opportunities. The child client as well as family members may view mental disability as a moral weakness or as a punishment for past misconduct. The idea of mental disability in general, or even a particular diagnosis, may carry moral, religious, or cultural significance. There may be disagreement within the family about the appropriate response to a child's mental disability. Indeed, the mental disability proceeding may be occurring precisely because there is a conflict within the family or between parent and child about these matters.

A legal finding that a child is mentally disabled may be perceived—by the child client or the parents—as a positive step. It can reinforce and validate the client's or the family's understanding that the child has a serious problem and needs assistance. It may also be seen—by the child or the parents—as a way of identifying the "troublesome" or "bad" individual who needs to be isolated from the rest of the "good, healthy" family or community. An important part of counseling the child client, as well as interacting with the child's parents, is determining and addressing their hopes and fears about the significance of a legal finding of mental disability.

The lawyer should inform and counsel the child client about the impact a legal finding of mental disability may have both short-term and long-term. For example, if the client is facing serious penal code charges in juvenile court, a voluntary hospitalization for mental health treatment may be critical to a later disposition plan under which the child is placed in a special group home rather than in a juvenile corrections facility. In such a case, the identification as mentally disabled may benefit the child client—both by providing treatment and by enabling a less restrictive disposition. On the other hand, a record (albeit a juvenile court one) that explicitly connects mental disability with law violation—and thus labels the child as "mentally ill and dangerous"[235]—may have an adverse effect on later educational or employment options.

Because stigma may be increased by a legal finding of mental disability and of the need for secure confinement, the lawyer should try to obtain the least restrictive, least stigmatizing placement consistent with the client's wishes and needs. The lawyer should explore whether the child client can get the services he or she needs and wants without a legal finding of mental disability, or with such a finding but without an involuntary commitment. In doing so the lawyer should be guided by what the client thinks is best and most "therapeutic" for him or her. The lawyer should strive to make whatever happens in the legal proceeding less traumatic and thus perhaps more "therapeutic" by treating the child client with respect and encouraging others to do so.

Assuming that the child client does indeed have a mental disability, this may be a lifelong condition. As part of empowering the client, the lawyer should encourage him or her to learn about the mental disability, to understand the significance of the diagnosis, and to become familiar with treatment options and resources and the benefits and negatives of each. Generally speaking, whether or not the child client is capable of understanding this information, the lawyer should try to work with parents to make sure

they are able to assist the child in the future. Especially when the client is preverbal or impaired, parents and mental health professionals who will be involved with him or her on a long-term basis also need to know about available resources and the child's legal entitlement to them.

Resisting the Temptation to Play Therapist

Representing a mentally disabled client presents a particular temptation for the lawyer: to act not as the client's attorney but as a therapist. As discussed earlier, courts that regularly hear mental disability matters develop a unique environment, a blend of the two "cultures" of law and mental health.[236] The court or hearing officer, caseworkers, court personnel, expert witnesses, and lawyers use not only the language and concepts of the law but also those of psychiatry and psychology. Even when the issue before the court involves a *legal* question, parties or the court commonly use "best-interest" and "therapeutic" language and concepts. Court personnel as well as mental health professionals may refer to the client as "the patient," reflecting an unspoken assumption that the client is mentally disabled and needs treatment.

In such an environment, avoiding role confusion and preserving a traditional lawyer-client relationship may be especially difficult for a lawyer. The lawyer may be confronted by family members saying, "Can't you see that [the client] is sick and needs to be in the hospital?" A treating mental health professional may ask the lawyer to avoid legal action that will reinforce the client's delusional thinking or resistance of treatment. The judge or hearing officer may ask the lawyer's opinion about which treatment option is in the client's best interests. The child client also may perceive the lawyer as another adult who is trying to provide "treatment" or to determine the child's "best interest." Depending upon the child's attitude, this misunderstanding may encourage him or her to confide in the lawyer as in a therapist or to distrust the lawyer as just another adult who is part of the mysterious system determining his or her fate.

Often lawyers are attracted to mental disability law because of a personal connection. A lawyer may have an educational or employment background in psychology, social work, or public health, for example. Sometimes a lawyer's family member has a mental disability. Personal familiarity with mental disability as well as related education or employment experience can be great assets to a lawyer but also can present great dangers. The lawyer may identify with the client's relatives and adopt their view of the situation. Or the lawyer may identify with the client and project upon him or her the lawyer's own memories and desires, rather than seeing the client as an individual. The lawyer may identify with the mental health professionals and try to ingratiate him- or herself with an expert witness or a treatment team. Finally, a lawyer who has chosen to represent children or people with mental disabilities may have an especially strong desire to see him- or herself and be seen as a "good person." Such a lawyer can find it especially difficult to withstand criticism or anger from the client's family members or pressure from court personnel or mental health professionals to "go along with" what everyone else believes is best for the child client.

As discussed below, a well-qualified lawyer should be familiar with the language and concepts of mental health law. He or she should understand the possible effects of mental disability on the client, the significance of diagnoses, and the risks and benefits associated with common treatment methods, including psychotropic medications. This base of knowledge enables the lawyer to accurately assess the merits of the client's case and communicate effectively with mental health professionals. It does not qualify the lawyer to be a therapist, however.

Even if the lawyer is a mental health professional with a degree in psychiatry, psychology, or social work, he or she must still resist the temptation to "combine" the two professional roles. The lawyer is acting as a lawyer, not as a therapist, in the relationship with the child client and should explain and maintain that role clearly and consistently. Switching back and forth between roles or picking and choosing which professional obligations to honor is unfair and confusing to the client.

Nevertheless, the lawyer can and should use the expertise of a mental health professional in carrying out his or her ethical duties to the child client. For example, the lawyer can use professional interviewing skills to more effectively communicate with the client and knowledge of treatment models to explain the risks and benefits of each to the client. He or she cannot, however, undertake to "treat" the child client in the guise of giving legal advice or recommend a treatment or placement option to the court (or to opposing counsel or the treating mental health professional) that is inconsistent with the client's wishes. Such a lawyer should be especially wary of misusing his or her mental health professional skills to manipulate the child client into agreeing with legal advice. Because the mentally disabled child client is so vulnerable to pressure from an adult, the lawyer should make every effort to ensure that the client's decision is uncoerced.

In summary, the lawyer must understand and communicate consistently that he or she is a lawyer, not a therapist. The lawyer has the unique obligation to identify and pursue the client's *legal* interests; he or she should not duplicate the role of others in making a "best-interest" decision. Resisting the pressure of the special court culture may

continue to be difficult, but performing the lawyer's role will be easier if he or she clearly explains it to the client, family members, and mental health professionals. Over time, if the lawyer is consistent in his or her role, the court personnel and mental health professionals who regularly participate in mental disability proceedings will learn to expect and accept it.

Although the lawyer should refuse to function as a therapist or a guardian ad litem, he or she can and should use mental health concepts and language when communicating with the court and mental health professionals.[237] A lawyer can appropriately argue that an action is in the client's "best interest" or "therapeutic" where these terms are likely to be persuasive to the decision-maker.[238] However, the lawyer can do so only where this approach advances the client's *legal* interest.

As a helpful corrective to the temptation to act as a therapist, the lawyer should assume that the client's *legal* interest, *at minimum*, includes preservation and enforcement of his or her rights under the relevant statutes and state and federal constitutions. For example, in California, the mission statement of the Lanterman-Petris-Short Act[239] can provide a helpful checklist of such rights:

> The mission of California's mental health system shall be to enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

Consistent with this statement, the lawyer for a child client in mental disability proceedings should identify and pursue the course of action that will enable that client to (1) *access services and programs* that (2) *assist him or her in better controlling the illness* (or accommodate the disability), thereby allowing the client to live the most constructive and satisfying life possible. The programs and services should be (3) *individually tailored to the client's needs* and (4) *permit him or her to live in the least restrictive available setting*.

The emphasis in this language is on giving the client access to services and programs, rather than imposing involuntary treatment, and assisting the individual client with the goal of maximizing his or her opportunities for a meaningful life—a provision of special importance in representing a child client. True, the mission statement assumes that the child client does have a mental illness or disability and limits the right to the least restrictive *available* placement, but it still reflects the LPS Act's preference for voluntary over involuntary treatment, for community placement over hospitalization, and for preservation of liberty to the maximum extent possible consistent with the needs for safety and treatment. Unless instructed to the contrary by his or her client, the lawyer should assume that the client's wishes and *legal interest* are best served by legal action consistent with the LPS Act's mission statement and philosophy.

TRAINING FOR LAWYERS IN MENTAL DISABILITY PROCEEDINGS

Of course, lawyers need to know the legal rights of their clients under state and federal constitutions and statutes. But a well-qualified lawyer should also be familiar with the language and concepts of mental health professionals. Without such training, the lawyer may easily be intimidated and bewildered by this unfamiliar "culture" and may not know when to consult mental health professionals or, alternatively, may inappropriately defer to them. Training should also help the lawyer perform the critical function of "translating" legal concepts to lay people, including his or her client, the client's family members, and mental health professionals.

The lawyer also needs to be familiar with the most common *diagnoses* and comfortable using the *Diagnostic and Statistical Manual of Mental Disorders*.[240] He or she should know about the different *treatment* methods generally regarded as consistent with good professional practice and should be familiar with the *codes of ethics* and *licensing standards* used by mental health professionals. The lawyer should *visit* treatment and services programs available in his or her area and review information about model or innovative programs in other places.

The lawyer must be educated about the *medications* commonly prescribed to treat mental disability. He or she must be able to use the *Physician's Desk Reference* and to research possible negative side effects and contraindications of a given medication or combination of medications. The lawyer needs to understand how the medications may affect, positively or negatively, the client and his or her ability to communicate or make decisions.[241]

Reaching a diagnosis, providing treatment, and prescribing medication are all decisions falling under the expertise of mental health professionals, not lawyers, but to serve the client effectively a lawyer must know enough about all these matters to recognize any possible problems. At that point the lawyer can and should call upon an appropriately qualified mental health professional for guidance. To do this, the lawyer must be aware of the different types of mental health professionals, including their training and expertise. He or she should know which tests are most commonly administered and by what type of

mental health professional and the tests' reliability and admissibility for forensic use.

Perhaps most important, the lawyer must be educated in the *effect of mental disability* on the client. To effectively represent any child client, the lawyer needs to be trained in *child development* and its possible effects on the child's ability to understand and participate in decision-making as well as the effects of different mental disabilities. This knowledge can assist the lawyer in determining the client's capacity and working to maximize the child client's participation in the lawyer-client relationship.

Especially when representing a child client, the lawyer must consider the ways in which a mental disability may affect the client *in the future*. Thus, the lawyer should be well informed about the ability of people with different mental disabilities to function in society. The lawyer should visit programs providing services to *adults* with mental disabilities and talk with them about their experiences in education, employment, and family life.

Finally, the lawyer should be trained in the special ethical problems that have been the subject of this article and in the professional standards that address them.

CONCLUSION

California provides procedural due process protections, including the right to counsel in administrative and judicial proceedings, for children with mental disabilities. For lawyers/advocates to provide effective legal representation, however, they must be familiar with the client's legal rights under state and federal statutes and constitutions. They must have a clear understanding of their professional role and their unique duty to identify and pursue the client's *legal interests* and avoid functioning as a guardian ad litem or therapist. They must be comfortable with the language and concepts of the mental health "culture" and be able to use them in communicating with mental health professionals and the court consistent with the client's *legal* interest. By skillful and zealous representation they must seek to empower the child client and to help fashion for him or her a future filled with possibilities.

NOTES

1. *See, e.g.*, Model Code of Professional Responsibility EC 7-12, and Model Rules of Professional Conduct Rule 1.14.

2. *See, e.g.*, ABA Standards of Practice for Lawyers Representing a Child in Abuse and Neglect Proceedings (1996); Representing Children: Standards for Attorneys and Guardians Ad Litem in Custody or Visitation Proceedings, Standards 1.1, 2.4 (Am. Academy of Matrimonial Lawyers 1995); and IJA–ABA Standards on Representing Private Parties (Institute of Judicial Admin.–American Bar Ass'n 1979).

3. Cal. Welf. & Inst. Code § 317(c) (West Supp. 1999).

4. *See generally* Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence (David B. Wexler & Bruce J. Winick eds., Carolina Academic Press 1996); David B. Wexler & Bruce J. Winick, Essays in Therapeutic Jurisprudence (Carolina Academic Press 1991). "Therapeutic jurisprudence" (TJ) studies the role of law as a therapeutic agent, considering whether substantive rules, legal procedures, and lawyers' roles can or should be altered to enhance their therapeutic potential. For examples of scholarship applying TJ concepts, *see* Stephen H. Behnke & Elyn R. Saks, *Therapeutic Jurisprudence: Informed Consent as a Clinical Indication for the Chronically Suicidal Patient with Borderline Personality Disorder, Symposium on Mental Disability Law,* 31 Loy. L.A. L. Rev. 945 (1998); Keri K. Gould, *A Therapeutic Jurisprudence Analysis of Competency Evaluation Requests: The Defense Attorney's Dilemma,* 18 Int'l J.L. & Psychiatry 93 (1995); Deborah A. Dorfman, *Effectively Implementing Title I of the Americans With Disabilities Act for Mentally Disabled Persons: A Therapeutic Jurisprudence Analysis,* 8 J.L. & HEALTH 105 (1993); Daniel W. Shuman, *Therapeutic Jurisprudence and Tort Law: A Limited Subjective Standard of Care,* 46 SMU L. Rev. 409 (1992).

5. Welfare and Institutions Code section 5320 requires each county to appoint or contract for the services of patients' rights advocates to protect and enforce the rights of patients. Patients rights advocates investigate complaints, monitor mental health facilities for compliance with legal protections for patients, and provide training and education in mental health law. They also provide representation at a variety of administrative hearings.

6. *In re* Roger S., 569 P.2d 1286 (Cal. 1977); *In re* Michael E., 538 P.2d 231 (Cal. 1975).

7. See discussion of *In re Roger S.*, in text accompanying notes 56–74.

8. Cal. Welf. & Inst. Code §§ 5585–5585.59 (West 1998) (AB 4642; Stats. 1988 ch. 1202).

9. The Lanterman-Petris-Short Act, Stats. 1067, ch. 1667, § 36 (operative July 1, 1969) (codified at Cal. Welf. & Inst. Code § 5000 et seq.), which establishes the system of public mental health care in California. Its provisions apply to, inter alia, voluntary and involuntary treatment, conservatorships, and patients' rights. The Bronzan-McCorquodale Act (formerly the Short-Doyle Act), Stats. 1968, ch. 989 § 2 (operative July 1, 1969) (codified at Cal.Welf. & Inst. Code § 5750 et seq.), governs the

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administration and funding of the state mental health system.

10. Cal. Welf. & Inst. Code § 5150 (West 1998). The 72-hour detention authorized by this provision is often referred to as a "5150 hold."

11. Stephen H. Behnke et al., The Essentials of California Mental Health Law 74 (W.W. Norton 1998).

12. Cal. Welf. & Inst. Code § 5585.25 (West 1998).

13. Cal. Welf. & Inst. Code § 5585.50 (West 1998).

14. Cal. Welf. & Inst. Code § 5885.52 (West 1998).

15. *Id*.

16. Cal. Welf. & Inst. Code § 5585.53 (West 1998).

17. Cal. Welf. & Inst. Code § 5250 (West 1998).

18. Cal. Welf. & Inst. Code § 5260 (West 1998).

19. Cal. Welf. & Inst. Code § 5270.15 (West 1998).

20. Cal. Welf. & Inst. Code § 5300 (West 1998).

21. Cal. Welf. & Inst. Code § 5275 (West 1998).

22. Cal. Welf. & Inst. Code §§ 5350–5371 (West 1998).

23. Cal. Welf. & Inst. Code § 5357 (West 1998).

24. Welfare and Institutions Code section 5350(d) provides that the proposed conservatee can choose between a court and a jury trial on the issue of grave disability. This right to jury trial also applies in subsequent proceedings to renew a conservatorship.

25. This is an instance in which California law provides greater procedural due process protections than the U.S. Constitution. *Compare* Addington v. Texas, 441 U.S. 418 (1979) (standard of proof in civil commitment proceedings must be greater than preponderance of evidence but need not be beyond a reasonable doubt to satisfy due process) and Conservatorship of Roulet, 23 Cal. 3d 219, 590 P.2d 1 (1979) (standard of proof in LPS conservatorship must be beyond a reasonable doubt).

26. Cal. Welf. & Inst. Code § 5362 (West 1998).

27. *See id.* § 5364 (West 1998).

28. *See id.* § 5358.3 (West 1998).

29. "Psychotropic" refers to medication prescribed for treatment of thought or mood disorders and includes antipsychotics, antidepressants, and antimanic agents. *See* Robert J. Waldinger, Fundamentals of Psychiatry 397 (American Psychiatric Press 1986).

30. Cal. Welf. & Inst. Code § 5332–5336 (West 1998).

31. Riese v. St. Mary's Hosp. & Med. Ctr, 271 Cal. Rptr. 199 (Cal. 1987), *appeal granted*, 751 P.2d 893 (Cal. 1988), *appeal dismissed*, 774 P.2d 698 (Cal. 1989).

32. Cal. Welf. & Inst. Code §§ 5150–5360 (West 1998).

33. Behnke et al., *supra* note 11, at 182–83.

34. Cal. Welf. & Inst. Code §§ 5150–5360 (West 1998).

35. AAP v. Lungren, 940 P.2d 797 (Cal. 1997).

36. *Id.* at 854 (Mosk, J., dissenting): "From *In re Roger S.*, we may derive the following principles. First, an unemancipated minor's constitutional rights are not equal to, but are more limited than, those of an adult, both as against his or her parents and as against the state. Second, *an unemancipated minor has a right to procedures that will protect him or her from arbitrary and drastic curtailment of constitutional rights by his or her parents, or, presumably, the state, no manner* [sic] *how well motivated.* Third, a mature unemancipated minor, as opposed to one who is immature, has a increased right to exercise her constitutional rights, but even a mature unemancipated minor, as opposed to one who is immature, is not entitled to all the same procedural protections as an adult in the same situation." (Italics added.)

37. The abortion decision (1) has critical implications for the child's future; (2) is time sensitive (*see* Bellotti v. Baird, 443 U.S. 622, 642 (1979); AAP v. Lungren, 940 P.2d at 815, 66 Cal. Rptr. at 228); and (3) is inextricably linked with an individual's personal values (*see* Planned Parenthood v. Casey, 505 U.S. 883, 850–51 (1991); AAP v. Lungren, 940 P.2d at 813, 66 Cal. Rptr. at 226).

38. See Jan C. Costello, *Making Kids Take Their Medicine: The Privacy and Due Process Rights of De Facto Competent Minors, Symposium on Mental Disability Law*, 31 Loy. L.A. L. Rev. 907, 924–26 (1998).

39. Cal. Welf. & Inst. Code § 5585.10(b) (West 1998).

40. Cal. Welf. & Inst. Code § 300 (West 1998). This is a broad summary of a very long and detailed code section.

41. Cal. Welf. & Inst. Code § 601 (West 1998).

42. Cal. Welf. & Inst. Code § 602 (West 1998).

43. Cal. Welf. & Inst. Code § 6551 (West 1998).

44. *Id.* The 72-hour detention is, of course, pursuant to Welfare and Institutions Code section 5150.

45. 538 P.2d 231 (Cal. 1975).

46. Cal. Welf. & Inst. Code § 6551 (West 1998).

47. Under Welfare and Institutions Code section 5260.

48. See discussion of voluntary application under Welfare and Institutions Code section 6552, at text accompanying notes 50–54 *infra.*

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49. Cal. Welf. & Inst. Code § 5250, 5260, 5270.10, or 5300 (West 1998).

50. *See id.* § 6552.

51. *Id.*

52. *See* Cal. Welf. & Inst. Code § 317(c) (West Supp. 1999).

53. *See id.* § 634.

54. *Id.*

55. For a very early identification of this problem and use of the term "volunteering," see James W. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Cal. L. Rev. 840 (1974). For a much expanded and more recent discussion, see James W. Ellis, *Voluntary Admission and Involuntary Hospitalization of Minors*, *in* Law, Mental Health and Mental Disorder 487–99 (Bruce D. Sales & Daniel W. Shuman eds., Brooks/Cole 1996).

56. *Roger S.*, 569 P.2d at 1286.

57. *Id.* at 1288.

58. *Id.* at 1296.

59. *Id.* at 1290.

60. 442 U.S. 584 (1979).

61. Parham v. J.R., 442 U.S. at 600; *Roger S.*, 569 P.2d at 1288.

62. Parham v. J.R., 442 U.S. at 607.

63. *Id.* at 611, 613.

64. *Id.* at 612.

65. *Id.* at 619.

66. *Id.* at 600.

67. *Id.* at 601.

68. *Id.* at 606.

69. *Roger S.*, 569 P.2d at 1295: "We emphasize here our assumption that the great majority of parents are well motivated and act in what they reasonably perceive to be the best interest of their children. That fact cannot, however, detract in any way from the child's right to procedures that will protect him from arbitrary curtailment of his liberty interest in such a drastic manner no matter how well motivated."

70. *Id.* at 1290.

71. *Id.* at 1295: "[Petitioner was] confined in a complex which has barred windows and locked doors in an open ward with 40 other minors some of whom are so severely disturbed that they are unable to dress themselves. He alleges that he has been approached sexually by other boys whose advances he has repelled, and he fears further such advances. While he has been hospitalized two other minors have attempted suicide."

72. *Id.:* "The focus of our attention must be to delineate procedures that will ensure the child a fair opportunity to establish that (1) he is not mentally ill or disordered, or that, even if he is, confinement in a state mental hospital is unnecessary to protect him or others and might harm rather than improve his condition."

For a recent discussion of the interests at stake and the importance of a precommitment hearing for minors, *see* James W. Ellis, *Some Observations on the Juvenile Commitment Cases: Reconceptualizing What the Child Has at Stake*, 31 Loy. L.A. L. Rev. 929 (1998).

73. *Roger S.*, 569 P.2d at 1296.

74. The staff of the Office of Patients Rights Advocates advise and represent children in some *Roger S.* proceedings in Los Angeles County.

75. Cal. Welf. & Inst. Code § 6002.15 (West 1998).

76. *See, e.g.*, Mike A. Males, Scapegoat Generation 242–53 (Common Cause Press 1996) (critiquing unnecessary hospitalizations as "treatment of 'Kid-With-Insurance' Disorder"); Ira M. Schwartz, (In)justice for Juveniles: Rethinking the Best Interests of the Child 131, 131–48 (Lexington Books 1989) (characterizing unnecessary hospitalization as "being abused at better prices"); Jan C. Costello & Nancy L. Worthington, *Incarcerating Status Offenders: Attempts to Circumvent the Juvenile Justice and Delinquency Prevention Act*, 16 Har. C.R.-C.L. L. Rev. 41, 61–72 (1981) (identifying inappropriate use of the mental health system to circumvent restrictions on juvenile court power to confine status offenders); Carol A.B. Warren & Patricia Guttridge, *Adolescent Psychiatric Hospitalization and Social Control*, *in* Mental Health and Criminal Justice 119, 199–22 (Linda A. Teplin ed., Sage Publications 1984) (discussing inappropriate hospitalization of adolescents as a means of social control); Lois A. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 Stan. L. Rev. 773, 831–34 (1988) (linking dramatic increase in hospitalization to inappropriate admissions of "troublesome youth").

On the especially controversial use of such placements by parents hoping to "cure" their lesbian or gay children, *see* Beth E. Molnar, *Juveniles and Psychiatric Institutionalization: Toward Better Due Process and Treatment Review in the United States*, 2 Health & Hum. Rts. 99, 102–05 (1995).

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In an attempt to address this problem, California Welfare and Institutions Code section 6002.10(e)(1) provides: "A minor shall not be considered mentally disordered solely for exhibiting behaviors specified under Sections 601 [status offender] or 602 [juvenile delinquent]."

77. Welfare and Institutions Code section 6002.30 provides: "[T]he psychiatrist conducting the review shall privately interview the minor …."

78. Welfare and Institutions Code section 6002.20 provides: "The role of the advocate shall be to provide information and assistance to the minor relating to the minor's right to obtain an independent clinical review to determine the appropriateness of placement within the facility. The advocate shall conduct his or her activities in a manner least disruptive to patient care in the facility."

79. Welfare and Institutions Code Section 6002.10 provides: "It is the intent of the Legislature that this act shall not preclude the right to review of inpatient treatment through the exercise of other legal remedies available to minors, including but not limited to, a writ of habeas corpus."

80. Individuals With Disabilities Education Act (IDEA), 20 U.S.C. § 1400 et seq. (Supp. 1997).

81. Joseph Tulman, *The Best Defense Is a Good Offense: Using Special Education Advocacy in Delinquency Cases*, 15 ABA Child L. Prac. 97, 102 (1996).

82. The Early Periodic Screening Diagnosis and Treatment (EPSDT) entitlement was the result of a 1989 amendment to the Federal Medicaid Act, 42 U.S.C. § 1396d(a)(4)(B) (Supp. 1997). The EPSDT mandates that eligible children are entitled to receive, through their state's Medicaid system, any treatment listed in the Medicaid Act that is "medically necessary," even though it is not available to adults in the state.

83. *See* James Preis, *Advocacy for the Mental Health Needs of Children in California, Symposium on Mental Disability Law*, 31 Loy. L.A. L. Rev. 937 (1998) (describing effective litigation strategy using entitlements under federal EPSDT and Medicaid programs to develop a full range of mental health services for children). *See also* Melinda Bird, *The Integration of the ADA and the Problem of De-institutionalization, Symposium on Mental Disability Law*, 31 Loy. L.A. L. Rev. 847, 854–57 (1998) (discussing use of EPSDT and the integration mandate of the Americans With Disabilities Act to develop community-based programs and services for people with disabilities).

84. Lois A. Weinberg et al., *Advocacy's Role in Identifying Dysfunctions in Agencies Serving Abused and Neglected Children*, 2 Child Maltreatment 212, 212–13, 223–24 (1997).

85. *Id.* at 223–24.

86. Therese Glennon, *Disabling Ambiguities: Confronting Barriers to the Education of Students with Emotional Disabilities*, 60 Tenn. L. Rev. 295, 364 (1993).

87. Joseph Tulman, *supra* note 81, at 102.

88. California Family Code section 3150 provides for appointment of counsel to represent a child in a custody or visitation proceeding if the court determines that it would be in the best interest of the child.

89. California Family Code section 3170(a) provides: "If … custody, visitation, or both are contested, the court shall set the contested issues for mediation."

90. ABA Presidential Working Group on the Unmet Legal Needs of Children and Their Families, America's Children at Risk: A National Agenda for Legal Action 7 (American Bar Ass'n 1993).

91. See William. S. Johnstone, Jr., & Susan T. House, California Conservatorships and Guardianships, § 15.10 (Cal. Cont. Ed. Bar 1995): "The tension between the client's demands and his or her best interest often results in the attorney's failure to present the client's demands in a meaningful or persuasive manner."

See generally Thomas Litwak, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 Cal. L. Rev. 816 (1974); Grant Morris, *Conservatorship for the "Gravely Disabled": California's Declaration of Non-independence*, 15 San Diego L. Rev. 201 (1978); Virginia Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C. L. Rev. 1027 (1982); Michael Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 J.L. & Contemp. Prob. 161 (1982); Michael Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 J.L. & Hum. Behav. 37 (1992); Grant Morris, *Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 San Diego L. Rev. 343 (1995).

92. Robert F. Kelly & Sarah H. Ramsey, *The Legal Representation of Children in Protection Proceedings: Some Empirical Findings and a Reflection on Public Policy*, 34(2) J. Fam. Rel. 277, 282 (1985).

93. An excellent resource that summarizes this literature is *A Judge's Guide to Improving Legal Representation of Children* (May 1998), by the ABA Center on Children and the Law. *See generally Special Issue: Ethical Issues in the Legal Representation of Children*, 64 Fordham L. Rev. 1281 (1996).

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94. On the issue of rolelessness for counsel in mental disability proceedings, *see* Jan C. Costello, *"Why Would I Need A Lawyer?" Legal Counsel and Advocacy for People With Mental Disabilities*, in Law, Mental Health and Mental Disorder 15, 30–31 (Bruce D. Sales & Daniel W. Shuman eds., Brooks/Cole 1996).

95. *Id.* at 30.

96. Bruce A. Green & Bernadine Dohrn, *Children and the Ethical Practice of Law*, 64 Fordham L. Rev. 1281, 1289 (1996).

97. Robert N. Waxman, California Juvenile Court Practice: Delinquent Minors (Cal. Cont. Ed. Bar 1988) at 3.14.

98. *See generally* James A. Holstein, Court-Ordered Insanity: Interpretive Practice and Involuntary Commitment (Aldine DeGruyter 1993); Carol Warren, The Court of Last Resort: Mental Illness and the Law (University of Chicago Press 1982).

99. *See generally* John Hubner & Jill Wolfson, Somebody Else's Children: The Courts, the Kids, and the Struggle to Save America's Troubled Families (Crown 1996) (describing in detail representative cases in Santa Clara County dependency and juvenile court); Edward Hume, No Matter How Loud I Shout: A Year in the Life of Juvenile Court (Simon & Schuster 1997) (describing representative cases in Los Angeles County's juvenile justice system).

100. Warren, *supra* note 98, at 9.

101. Model Code of Prof. Responsibility (1981).

102. Model Rules of Prof. Conduct (1983).

103. *See id.* Rules 1.2(a), 1.3, 3.2. *See also* California Rules of Prof. Conduct Rule 3-110.

104. Model Rules of Prof. Conduct Rule 1.2(a).

105. *See id.* Rule 1.2(c).

106. Model Code of Prof. Responsibility EC 7-7.

107. *See id.* EC 7-5.

108. However, the Model Rules acknowledge that "[a] clear distinction between objectives and means sometimes cannot be drawn, and in many cases the client–lawyer relationship partakes of a joint undertaking." Model Rules of Prof. Conduct Rule 1.2 cmt.

109. Model Code of Prof. Responsibility EC 7-8.

110. Model Rules of Prof. Conduct Rule 1.16(b)(3). *Compare* Cal. Rules of Prof. Conduct Rule 3-700. *But see* Costello, *supra* note 94, at 24 (where client is poor or confined in a mental institution, alternative counsel may be unavailable and withdrawing from representation may mean abandoning the client).

111. *See* Model Rules of Prof. Conduct Rule 1.14 cmt.: "[1] The normal client–lawyer relationship is based on the assumption that the client, when properly advised and assisted, is capable of making decisions about important matters."

112. Model Rules of Prof. Conduct Rule l.14, Client Under a Disability, provides:

> When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of minority, mental disability or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client–lawyer relationship with the client.
>
> A lawyer may seek the appointment of a guardian or take other protective action with respect to a client, only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest.

113. Johnstone & House, *supra* note 91, at § 15.10 ("proposed conservatee has the same right to zealous and competent representation as any other client"); § 15.31 (proposed conservatee's right to counsel); and § 15.110 (conservator petitions for renewal of conservatorship, but conservatee has right to court hearing or jury trial; conservatee can waive such hearing or trial and is not presumed incompetent by virtue of conservatorship).

114. *See* Waxman, *supra* note 97, at 3.14 (juvenile client, like adult criminal defendant, controls the waiver of the constitutional right to a speedy trial, the right to plead guilty or have a trial, the right to confront and cross-examine witnesses, the right to plead to a lesser offense, and the right to plead not guilty by reason of insanity). On the role of counsel in juvenile court, *see* further discussion of IJA–ABA Standards, *infra* at text accompanying notes 131–142.

115. Model Code of Prof. Responsibility EC 7-12.

116. *Id.*

117. Model Rules of Prof. Conduct Rule 1.14 cmt. 5.

118. The American Psychiatric Association, in its *Diagnostic and Statistical Manual of Mental Disorders*, at xxvii (4th ed. 1994)*(DSM-IV)*, cautions that the courts should not regard psychiatric diagnoses as determining *legal* concepts such as individual responsibility, disability, or competency. Nevertheless, courts and other legal forums routinely use the *DSM* for this purpose.

119. Model Rules of Prof. Conduct Rule 1.14 cmt. 1 provides: "When the client is a minor or suffers from a mental disorder or disability, however, maintaining the

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ordinary client–lawyer relationship may not be possible in all respect. Nevertheless, a client lacking legal competence often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being. Furthermore, to an increasing extent, the law recognizes intermediate degrees of competence. For example, children as young as five or six years of age, and certainly those of ten or twelve, are regarded as having opinions that are entitled to weight in legal proceedings concerning their custody."

120. Model Code of Prof. Responsibility EC 7-12.

121. Model Rules of Prof. Conduct Rule 1.14(b) cmt. 3 provides: "If a legal representative has not been appointed, the lawyer should see to such an appointment where it would serve the client's best interests. In many circumstances, however, appointment of a legal representative may be expensive or traumatic for the client. Evaluation of these considerations is a matter of professional judgment on the lawyer's part."

122. A really principled lawyer would not simply rely upon the client's lack of response during one interview, but rather would make further attempts to communicate with the client. A review of the client's medical records might inform the attorney whether the client is unresponsive to everyone or communicates with family members, clinical staff, or other patients. If the client does communicate with some individuals, the lawyer may seek their assistance in meeting with the client and gaining the client's trust.

123. Model Rules of Prof. Conduct Rule 1.14(b) cmt. 2 states: "The fact that a client suffers a disability does not diminish the lawyer's obligation to treat the client with attention and respect. If the person has no guardian or legal representative, the lawyer often must act as the de facto guardian. Even if the person does have a legal representative, the lawyer should as far as possible accord the represented person the status of client, particularly in maintaining communication."

124. *Id.*

125. Model Rules of Prof. Conduct Rule 1.14(b) cmt. 4 (citing Rule 1.2(d)).

126. *See* Stan Herr, *Representation of Clients With Disabilities: Issues of Ethics and Control*, 17 N.Y.U. Rev. L. & Soc. Change 609 (1989); Michael Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 J.L. & Hum. Behav. 37 (1992).

127. Model Code of Prof. Responsibility EC 7-12.

128. Johnstone & House, *supra* note 91, at § 15.10.

129. *Id. See also* Steven J. Schwartz et al., *Protecting the Rights and Enhancing the Dignity of People With Mental Disabilities: Standards for Effective Legal Advocacy*, 14 Rutgers L. Rev. 541, 570–71 (1983): "Consideration for the clients mitigates in favor of representing their subjective wishes. The primary deficit in their lives—the one that renders their legal needs greater than those of others—is the lack of self and community valuation. If advocates do not listen to their clients, respect their views, and assist them to achieve some measure of self-determination, it is not clear who will."

130. The recommendations of the Fordham Conference were published at 64 Fordham L. Rev. (1996).

131. Standards Related to Counsel for Private Parties (Institute of Judicial Admin.–American Bar Ass'n Commission on Juvenile Justice 1979) (hereinafter IJA–ABA Standards). *See generally* Jan C. Costello, *Ethical Issues in Representing Juvenile Clients: A Review of the IJA–ABA Standards on Representing Private Parties*, 10 N.M. L. Rev. 255 (1980).

132. For a discussion of the significance of "status offense" and "delinquent act," *see* discussion *supra* at text accompanying notes 40–42.

133. IJA–ABA Standards Standard 3.1(b)(ii)(b).

134. *See id.* Standard 3.1(b)(i).

135. Standard 3.3(d) permits disclosure of confidences with the informed consent of the juvenile client or without consent where such disclosure will not disadvantage the juvenile, where it will further the juvenile's interests, and where the juvenile is incapable of considered judgment.

136. IJA–ABA Standards Standard 3.1(b)(i).

137. *See id*. Introduction, at 3, 8, and Standard 4.2 note, at 99–101. The standards also rejected the adoption of a neutral amicus curiae role whereby the attorney simply presented the court with all relevant information concerning the child client.

138. *See id.* Standard 3.1(b)(ii)(c)(1).

139. *See id.* Standard 3.1(b) note, at 81–82.

140. Costello, *supra* note 131, at 274.

141. *Id.* at 267.

142. This is typically linked to a presumption that younger children are not capable of criminal intent.

143. ABA Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases (1996).

144. *See id.* Standard A-1.

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145. *See id.* Standard A-1 commentary.

146. *See id.* Standard H-5. The court should permit the child to be represented by private counsel "if it determines that this lawyer is the child's independent choice" and there is no conflict of interest. "The court should make it clear that the person paying for the retained lawyer does not have the right to direct the representation of the child or to receive privileged information about the case from the lawyer."

147. *See id.* Standard B-1.

148. *See id.* Standard A-1 commentary.

149. *See id.* Standard B-4.

150. *Id*. The commentary notes: "[T]he child may not want to assume the responsibility of expressing a position because of loyalty conflicts or the desire not to hurt one of the other parties. The lawyer should clarify with the child whether the child wants the lawyer to take a position or remain silent with respect to that issue or wants the preference expressed only if the parent or the other party is out of the room. The lawyer is then bound by the child's directive. The position taken by the lawyer should not contradict or undermine other issues about which the child had expressed a preference."

151. *See id.* Standard B-5.

152. *See id.* Standard B-5 commentary.

153. *Id*.

154. *See id.* Standard B-3 commentary.

155. *See id.* Standard B-5 commentary.

156. *See id.* Standard B-1 commentary.

157. *See id.* Standard B-1(5).

158. *See id.* Standard B-4 commentary.

159. *See id.* Standard A-1 commentary.

160. *See id.* Standard B-4 commentary.

161. *See id.* Standard A-1 commentary.

162. *See id.* Standard B-4(3).

163. *See id.* Standard B-3.

164. *See id.* Standard B-3 commentary.

165. *See id.* Standard B-4 commentary.

166. *Id*.

167. Cal. Welf. & Inst. Code § 317(c) (West Supp. 1999).

168. *See id.* § 317(e). *Compare* Bus. & Prof. Code § 6068(e) (attorney shall maintain inviolate the confidences of the client) and Zador Corp v. Kwan, 37 Cal. Rptr. 2d 754 (Cal. 1995) (attorney must not assume a position that is inconsistent with the interests of the client).

169. ABA Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases Standard B-1(7) (1996).

170. *See id.* Standard B-1(7) requires the attorney to "[i]dentify appropriate family and professional resources for the child." The commentary provides: "The lawyer can also identify family members, friends, neighbors, or teachers with whom *the child feels it is important* to maintain contact…." (Italics added.)

171. *See id.* Standard C-5. These services may include, but should not be limited to: (1) Special education and related services; (2) Supplemental security income (SSI) to help support needed services; (3) Therapeutic foster or group home care; and (4) Residential/in-patient and outpatient psychiatric treatment.

172. *See id.* Standard D-12 provides: "The child's attorney may request the court for authority to pursue issues on behalf of the child in other matters, including SSI and other public benefits, school/education issues, especially for a child with disabilities, and mental health proceedings."

173. *Recommendations of the Conference on Ethical Issues in the Legal Representation of Children*, 64 Fordham L. Rev. 1301 (1996) (hereinafter "Recommendations").

174. The Recommendations, *id.* at 1314 and 1352, advocate that further study should be given to the question of whether Model Rules of Professional Conduct Rule 1.14 adequately addresses the representation of children: "[C]onsideration might be given to amending Model Rule 1.14 to delete the term 'minority' and to adopting a separate Model Rule to address the representation of children, which would reflect the Recommendations."

175. Green & Dohrn, *supra* note 96, at 1293.

176. Recommendations, *supra* note 173, at 1301. Further, "[l]aws that require lawyers serving on behalf of children to assume responsibilities inconsistent with those of a lawyer for the child as the client should be eliminated." *Id.* at 1302.

177. *Id.*

178. Recommendations, *supra* note 173, at 1312. The Recommendations use the phrase "reasoned choice" to describe a competent child client's decision. They prefer this to the IJA–ABA term "considered judgment."

179. *Id.* at 1330 (Report of Working Group on Allocation of Decision-Making).

180. *Id.* at 1312.

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181. *Id.*

182. "When capacity becomes an issue the lawyer should consider the following factors for assessing capacity:
a. Child's developmental stage
   i. Cognitive ability
   ii. Socialization
   iii. Emotional development
b. Child's expression of a relevant position
   i. Ability to communicate with lawyer
   ii. Ability to articulate reasons
c. Child's individual decision-making process
   i. Influence-Coercion-Exploitation
   ii. Conformity
   iii. Variability and consistency
d. Child's ability to understand consequences
   i. Risk of harm
   ii. Finality of decision."
Recommendations, *supra* note 173, at 1313.

183. *Id.* at 1309.

184. *Id.* at 1329 (Report of Working Group on Allocation of Decision-Making). For detailed recommendations on training and education of child advocates, *see id.* at 1364–65.

185. *Id.* at 1341. This admonition may be of particular relevance to a lawyer representing a child in mental disability proceedings.

186. *Id.* at 1339 (Report of Working Group on Determining the Child's Capacity to Make Decisions). Without such a presumption, "any guidelines risk becoming a test that child clients must pass before they can obtain the same form of representation that is available to adults." *Id.*

187. Recommendations, *supra* note 173, at 1343.

188. *Id.* at 1344.

189. *Id.* at 1313.

190. *Id.* at 1344 ("how a child arrived at a decision … goes to the heart of whether a child has capacity").

191. *Id.* at 1345.

192. *Id.* at 1344.

193. *Id.* at 1345.

194. *Id.* at 1330.

195. *Id.*

196. Recommendations, *supra* note 173, at 1312 (Part V. Determining Whether a Verbal Child Is Capable of Directing the Representation).

197. *Id.* at 1342.

198. *Id.* at 1335.

199. *Id.*

200. *Id.*

201. Recommendations, *supra* note 173, at 1309.

202. *Id.* at 1332–33. If the attorney acts as the GAL, there is a "problem of nonaccountability; … [t]he child's GAL is not accountable to anyone because the client cannot formulate or express a position…. [T]he GAL [might] make a premature and largely subjective decision about the child's best interest." Thus the recommendations "would prohibit an attorney from serving the dual function of GAL and attorney in the representation of a preverbal child." *Id.*

203. Recommendations, *supra* note 173, at 1309.

204. *Id.* at 1310.

205. *Id.*

206. The phrase "the child in context" is associated with Professor Jean Koh Peters, who contributed a chapter from her book of the same name to the Fordham Symposium. *See* Jean Koh Peters, *The Roles and Content of Best Interests in Client-Directed Lawyering for Children in Child Protective Proceedings*, 64 Fordham L. Rev. 1505 (1996).

207. Recommendations, *supra* note 173, at 1310 (Recommendation IV.B.3.b).

208. *Id.* at 1309.

209. *Id.* at 1310.

210. *Id.* at 1311.

211. *Id.*

212. Recommendations, *supra* note 173, at 1310.

213. *Id.* at 1332–33 (Part IV. Decision-Making for the Preverbal Child).

214. *Id.* at 1320.

215. See, e.g., Robert Isaac & Samuel Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law 'Reform,'* 2 Cornell J.L. & Pub. Pol'y 89 (1992).

216. See John Ensminger & Thomas Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. Psychiatry & L. 5 (1978); Thomas Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. Rev. 433 (1992).

217. David Wexler & Bruce Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. Miami L. Rev. 979 (1991). *See also* Charles W. Lidz, *Coercion in Psychiatric Care: What Have We Learned From Research?* 26 J. Am. Acad. Psychiatry & L. 631 (1998).

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218. Warren, *supra* note 98, at 154.

219. Bruce J. Winick, The Right to Refuse Mental Health Treatment 327–28 (1997) (respecting a right to refuse treatment both promotes the patient's autonomy and enhances the likelihood of a positive treatment outcome).

220. Tyler, *supra* note 216, at 443.

221. The IJA–ABA Standards, *supra* note 131, Standard 7.5, cmt. at 144–45 (suggesting that involving the juvenile client in planning the disposition may motivate him or her to comply with the eventual court order): "This Standard emphasizes the importance of a professional demeanor in relationships with parents and court personnel as well as the juvenile client, suggesting that such behavior will increase client confidence in the justice process. Standard 9.5, referring to counseling after disposition, requires the attorney to 'urge upon the client the need for accepting and cooperating with the dispositional order,' even where the order is to be appealed. As part of that counseling role, it might be helpful for the attorney to remind the client of the attorney's own obligation, under Standard 7.4, to comply with all rules, orders, and decisions of the court. A distrustful juvenile client, who believes that the attorney is simply one of many adults with authority to make decisions concerning his or her placement or care may develop increased confidence upon learning the extent to which counsel is bound by, and attempts skillfully to utilize, the procedures and powers of the court." Costello, *supra* note 131, at 271 n.53.

222. *See* Weinberg, *supra* note 84.

223. ABA Standards of Practice for Lawyers Who Represent children in Abuse and Neglect Cases Standard D-6. Significantly, the standard provides: "Ultimately, the child's attorney is bound by the client's direction concerning testifying."

224. Recommendations, *supra* note 173, at 1332–33.

225. Standard 2.10 of Standards for Attorneys and Guardians ad Litem, *supra* note 2, provides: "When the client's decision-making ability is affected by emotional problems … an attorney should recommend counseling or treatment." The Comment further provides: "[An angry client may demand] a course of action that will escalate costs, prolong litigation, irritate the judge and raise the animosity level—but a course entirely within his or her legal rights. Even though the ultimate decision must be that of the client, before accepting a clearly detrimental decision, the attorney should attempt to dissuade the client and, if that fails, urge the client to counsel with others who might have a stabilizing influence: family, friends, therapists, doctor or clergyman…."

226. *Id.;* Standard 2.27 provides: "An attorney should refuse to assist in vindictive conduct toward a spouse or third person and should not do anything to increase the emotional level of the dispute. Comment: … [T]he attorney should attempt to convince the client to work toward family harmony or the interests of the children. Conduct in the interests of the children or family will almost always be in the client's long term best interests."

227. Model Code of Prof. Responsibility EC 7-10: "The duty of a lawyer to represent his client with zeal does not militate against his concurrent obligation to treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm."

228. IJA–ABA Standards, *supra* note 131, at Standard 1.4.

229. "To the extent that it is consistent with the attorney's primary task of protecting the client's rights, the attorney may and even should utilize those features of the juvenile justice system which reflect its arguably nonpenal, benevolent orientation. Thus conferences with court social workers and probation officers, exploration of diversion programs, referral for social, psychological, psychiatric or other services, may all be appropriately pursued where attorney and client agree they may benefit the client. [Stds. 1.4, 4.3., 5.2, 6.2]." Costello, *supra* note 131, at 268.

230. *See* Behnke & Saks, *supra* note 4, at 979: "When … definitions of 'therapeutic' diverge, therapeutic jurisprudence must offer some way of determining who will be the arbiter of what lies in the patient's best therapeutic interests."

231. For an excellent article on client empowerment, *see* Katherine Hunt Federle, *The Ethics of Empowerment: Rethinking the Role of Lawyers in Interviewing and Counseling the Child Client*, 64 Fordham L. Rev. 1655 (1996).

232. It is likely therapeutic to involve family members in the legal representation to the extent this is consistent with the expressed wishes of a competent client or a verbal but impaired client or with the clearly identified legal interests of a preverbal client. However, the lawyer should explain to the parents the lawyer's role and the limits of confidential communication.

233. This is especially important with a child client who may become more competent and less impaired as he or she grows older, even if the client still has a mental disability.

234. Costello, *supra* note 94, at 35.

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235. The U.S. Supreme Court has consistently found that statutory criteria for civil commitment as "mentally ill and dangerous" have been satisfied by a previous proceeding that found a link between mental disability and violation of law. Jones v. U.S., 463 U.S. 354 (1983) (upholding automatic commitment of persons found not guilty by reason of insanity even where charge involved nonviolent property crime); Hendricks v. Kansas, 521 U.S. 346 (1997) (upholding sexual predator commitment law where committed person had mental disability and had been found guilty of sexual crimes).

236. For a discussion of the differences between these two cultures, *see* Costello, *supra* note 94, at 17–19.

237. *See* Peters, *supra* note 206, at 1516–17 (lawyer should explain role to other professionals and show understanding of their best-interest orientation).

238. *Id.* at 1515 (lawyer should translate proposal into "best-interest" language if that is what court wants, even if actual legal issue is framed differently).

239. Cal. Welf. & Inst. Code § 5600.1 (West 1998).

240. *See supra* note 118, describing the *DSM-IV.*

241. *See* Jan Costello, *Representing the Medicated Client,* 7 Mental Disability L. Rep. 55 (1983); Kathi Grasso, *Children and Psychotropic Drugs: What's an Attorney to Do?,* 16 A.B.A. Child L. Prac. 49 (1997).